



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

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

Dydd Mercher, 12 Hydref 2011
Wednesday, 12 October 2011

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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Nuala Brennan	Ymgynghorydd Meddygol ym Maes Iechyd Cyhoeddus Fferyllol Consultant in Pharmaceutical Public Health
Anne Hinchliffe	Ymgynghorydd Meddygol ym Maes Iechyd Cyhoeddus Fferyllol Consultant in Pharmaceutical Public Health

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

Steve Boyce	Y Gwasanaeth Ymchwil Research Service
Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirpwry Glerc Second Clerk

Dechreuodd rhan gyhoeddus y cyfarfod am 10.52 a.m.
The public part of the meeting began at 10.52 a.m.

Ymchwiliad i'r Cyfraniad a Wneir gan Fferyllfeydd Cymunedol i Wasanaethau Iechyd yng Nghymru—Tystiolaeth gan Iechyd Cyhoeddus Cymru
Inquiry into the Contribution of Community Pharmacy to Health Services in Wales—Evidence from Public Health Wales

[1] **Mark Drakeford:** Bore da. **Mark Drakeford:** Good morning. I welcome Croesawaf aelodau'r pwyllgor yn ôl. Yr back committee members. We are now in ydym yn awr mewn sesiwn gyhoeddus. Yr public session. We will concentrate on our ydym yn canolbwyntio ar ein hymchwiliad i inquiry into community pharmacy services. I mewn i wasanaethau fferyllfeydd cymunedol. extend a very warm welcome to Anne

Estynnaf groeso cynnes iawn i Anne Hinchliffe, who is a consultant in Hinchliffe, sy'n ymgynghorydd meddygol pharmaceutical public health, and to Nuala ym maes iechyd cyhoeddus fferyllol, ac i Brennan. Both are representing Public Health Nuala Brennan. Mae'r ddwy yn cynrychioli Wales. Iechyd Cyhoeddus Cymru.

[2] I welcome you both. We are going to conduct this session in the way that we conducted earlier sessions with witnesses for this inquiry. I will ask you whether you have any opening remarks that you would like to make. Thank you very much for your paper, which committee members have had a chance to look at. When we have had a brief introduction from you, I will then throw the session open to committee members to ask questions. I hope that we will have a chance at the end to cover anything that we may not have asked you that you want to ensure we take away from the session and to ensure that you have an opportunity to cover any points in the way that you would like to. I should say at the start of this session that William Graham is not with us this morning; he has sent his apologies. Anne, would you like to begin?

[3] **Ms Hinchliffe:** Yes, thank you very much. Good morning. First, I would like to thank the committee for giving Public Health Wales the opportunity to present oral evidence today. Nuala and I are both members of the pharmaceutical team within Public Health Wales and, as such, we are part of NHS Wales. The team focuses on issues that relate to medicines and pharmaceutical services at a population level. Within public health, there are three main areas of work, all of which have relevance to community pharmacy. The first of the three areas is health improvement, which might include issues such as supporting adherence to medication and the management of chronic conditions. It might also be about providing advice for a healthy lifestyle. The second area is health protection. This might include issues such as medicine safety and reducing the transmission of infectious diseases. The third area that we work in is healthcare quality, which includes issues relating to assessing need, planning services to meet that need and evaluating the services that are provided for the people of Wales.

[4] So, our remit is much broader than the activities of community pharmacy. However, we think that the community pharmacy network in Wales has a significant contribution to make to public health, and we are therefore pleased to be able to contribute to this inquiry.

[5] **Ms Brennan:** I have nothing further to add.

[6] **Mark Drakeford:** Thank you very much. I will open it up to any Member who wishes to ask the first question.

[7] **Darren Millar:** Thank you for your paper. I was very interested in the section that you prepared on enhanced services. You make the point that there is no centralised and comprehensive list of all the enhanced services that are available in some community pharmacies. To what extent do you feel that might hinder the public's ability to understand the sorts of services that they might be able to access at their local pharmacy, and is that why we have been less successful in Wales than in some other parts of the UK in encouraging members of the public to present at a pharmacy, rather than at their local GP practice?

[8] **Ms Hinchliffe:** As you said, we do not have a centralised list, although we are working on that with a database of all pharmacy services. When I was picking that up, we were thinking more from the perspective of people who are planning services locally to try to understand what services are available. If people ask how services compare between one health board and another with our public health function, we would say that we find that more difficult than we would hope, because the only way that we can find it out is by asking individual health boards.

[9] In terms of patients, we know that information is given to NHS Direct Wales. If you go on to the NHS Direct website, you can look for a pharmacy close to your postcode and you can ask whether it provides certain services. So, I know that NHS Direct Wales wants to make it easier for the public to find those services, but NHS Direct needs to find its information from somewhere, too. We hope that we would have some accurate centralised databases so that we would know that if information was going on to the NHS Direct Wales website, it would be up-to-date and that it would be easy for the public to find it.

[10] **Darren Millar:** With respect, most people would not go to the NHS Direct website to check what was available at their local pharmacy before deciding where to present if they had a minor ailment. The point I am seeking your advice on is this: given that there is inconsistency in the approach taken towards community pharmacies and the services that they might be able to provide within local health board areas and from one local health board to the next, do you think that that presents a barrier to getting the best out of our community pharmacies, and to people from making more use of them, as they may not be sure what services are available?

[11] **Ms Hinchliffe:** There is signposting within the essential services in the community pharmacy contractual framework, which is very important. If someone comes to a pharmacy and they are interested in having a particular service, they can find out whether the service is available from their pharmacy or from another pharmacy, or whether it is provided by another provider in the health system. We have a list of essential services, and the public will know that all of those services are available from every pharmacy. We then get into issues of enhanced services and how you determine whether a service should be available from every pharmacy, or whether you say that, in making the most use of our resource, you would not want to have certain services in every single pharmacy in an area, because good provision is being made by other providers, or because you do not have the same level of health need within the population.

[12] **Darren Millar:** With it being hit and miss—you seem to be nodding, Nuala.

[13] **Ms Brennan:** Not to take anything away from what Anne said, our perspective, coming from where we operate, is about the information we require to perform our job. For the patient, what you are alluding to is how they know a particular pharmacy is offering a particular service. Anne highlighted that NHS Direct is one source of that information. The way in which health boards promote the services offered by their pharmacies is a matter that you would need to check with health boards. Pharmacists themselves are generally excellent business people, and therefore would, it is hoped, promote the services that they provide in their pharmacies. At the same time, you are right to say that service provision in Wales is inconsistent, but it may be appropriate, because we do not know what needs assessment has gone into the health board's decision to put a particular service in a particular locality. There may be a need to look at how that service is promoted to the public, so that there is not confusion.

[14] Added to that, pharmacies sometimes suffer from the fact that, if there is not a regular pharmacist in an establishment, there may be a locum on duty who does not have the appropriate accredited training to support an enhanced service. So, a member of the public may be disappointed because, on a particular day, that service may not be available to them. Unfortunately, that is the nature of some areas of pharmacy. There are many elements where the public requires more information about what is consistently available in particular pharmacies.

11.00 a.m.

[15] **Mark Drakeford:** I am going to go to Kirsty next, while she is still with us. *[Laughter.]*

[16] **Kirsty Williams:** One area that the committee has been looking at is whether a minor ailment scheme might be a good way of moving patients out of the health service and of dealing with them in a more appropriate and cost-effective way. Your paper seems to cast some doubt over whether a minor ailment scheme would be a good idea. I accept your concept because, feeling as I do today, I could go to the pharmacy and buy a plethora of over-the-counter medicines. However, if there was a minor ailment scheme, I might see the pharmacist and he might prescribe exactly what I would have bought, and the cost would be transferred to the NHS. However, what we were looking at is pharmacists being able to prescribe above and beyond what is available on the counter in front of them. I might go in with a small eye irritation and buy some Brolene, but that might not be sufficient to clear up what I have. If the pharmacist could give me something on prescription that I would otherwise have to go to the GP for, then that might be a more appropriate way of dealing with a minor eye infection or a bout of cystitis that does not clear up after over-the-counter medication. What are your views on that kind of minor injury service, where pharmacists would be able to prescribe medicine that could not be bought over the counter, but would usually require a trip to the GP?

[17] **Ms Hinchliffe:** We are now talking about quite a different level of service. There would need to be some further exploration into the extent to which such conditions are an issue. For example, with the eyes, previously you could get Brolene, but in the last decade chloramphenicol eye drops have been made available over the counter. There is certainly a move within the pharmaceutical industry so that, if products can be provided over the counter, they will be. Increasingly, there are products that you can purchase that, 10 years ago, you would have needed a prescription for—but clearly, not all of them. Sometimes, the reason why products cannot be purchased will be to do with antibiotic resistance and so on. You do not want to be giving mixed messages; you would have to ensure that you do not overexpose the population to antibiotics, because they would not be so useful when they are really needed. We would need to consider which issues a pharmacist could reasonably manage where people need a prescription-only medicine. It would be worth exploring that, along with whether they are conditions you could reasonably think a community pharmacist could manage. We have no issues with the fact that community pharmacists could manage what are generally considered minor ailments, because that is what they do all of the time with over-the-counter sales. However, you are moving into a new domain covering areas for which they do not traditionally provide over-the-counter sales. Therefore, it is about ensuring that they are competent and skilled to do that. To the extent that that is an issue, is that something that you want to invest your resources in?

[18] **Vaughan Gething:** Following on from what has been said about the different schemes that we may wish to adopt for community pharmacies, what struck me that in your paper was the number of times where you say data was often not available. That was the case throughout the paper, and not just for one particular element. I found that quite frustrating. How are the data collected and collated, and who is responsible for that, or is it simply that you have not been given the data after requesting them? In section 5, on the penultimate page, there is a question about the potential impact of providing other services in community pharmacy—of which a minor ailment scheme is one—and any cost savings that they may offer. The response was not particularly helpful, because you say that the development of community pharmacy services

[19] ‘may offer improved availability and/or access and should not be considered from a financial perspective only’.

[20] That is fair enough, but I do not think that it answers the question about whether they

would achieve any savings or, if not, what the basis was for coming to that sort of view.

[21] I also had a question about medicine use reviews. I am interested in these, because I recently had one myself. I know that you have cited a paper from England from three years ago, the findings of which were counterintuitive: where you would expect medicine use reviews to have most impact and benefit is where they are least likely to take place. Could you give a little more clarity on why you think that that may be the case? How can you ensure that there is a more consistent approach, to ensure that they take place in areas of greatest benefit?

[22] **Ms Brennan:** I will try to respond to you on the data question. The pharmacy contract does not necessarily require the provision of data to the health boards. The difficulty that pharmacies have is that their IT infrastructure is less established than that in GP practices. Using the example of medicines use reviews, although we may know the number of medicines use reviews that have been performed across Wales, we do not have any detail on what medicines are being reviewed and we do not know the demographics around the patient being reviewed. Therefore, in past years, the data that we got from health boards around community pharmacy activity were around activity levels.

[23] On the new enhanced services that are being developed, which all health boards have been asked to provide—such as needle exchange or, particularly, the new emergency hormonal contraceptive provision service—we have had some input into the service specifications for that contract since coming to work in Public Health Wales. We have built into the service specification of that contract the requirement for pharmacists to provide more information than they would have done in the past. So, we can now access those data and pull from them some demographic information about individuals accessing the new service, which was launched this year.

[24] That has particularly been enabled by the advances in the e-payment system. Pharmacists now key in information and transfer it to NHS Wales Informatics Service, which means that it is retrievable in a format that we can interrogate for intelligence. As previous witnesses may have alluded to with the GP systems—where they can pull information out of what is called an Audit Plus software programme—we would hope that, over time, we could do the same with the community pharmacy software systems and payment claims systems. However, we need to build in the requirement to provide the information in order for the information to be there. Most of the information around community pharmacy services in the past has been around opening hours, the numbers of prescriptions dispensed and activity levels, as opposed to the useful information that you might want to draw from the service itself.

[25] So, things are moving and it is a work in progress. We have been advising NWIS on the type of information that you would want to be able to gather, particularly in relation to giving some kind of picture of, for instance, the prevalence of needle exchange or substance misuse supervision—the kind of enhanced services that pharmacies have traditionally been involved with but on which we did not get information through the old contract. Is that helpful on the data side of things?

[26] **Vaughan Gething:** Yes, in terms of telling us where we are. It is difficult, and we will always want to evaluate the success or otherwise of any service that is provided. If we make recommendations, but do not really know what is happening, because people have only told us what might happen, it will leave us in a weaker position to make useful recommendations about the value of what is already being provided, and any recommendations that we may make for the future. That leaves us in a more difficult position.

[27] **Ms Brennan:** We wholeheartedly agree with you on that. We encourage building

evaluation into any services as they are established. It has been quite difficult to go back in time to try to find out what the reach and cost of the minor ailments scheme in Torfaen has been. When we have looked for published information, it is not there. Pharmacies and many front-line primary care professionals find it difficult to stop the bus and evaluate something. It is down to the commissioners, when they commission a service or establish a pilot scheme, to build in the need for evaluation at the outset, so that we can determine whether something is working or not.

[28] **Ms Hinchliffe:** On medicines use reviews, it is difficult for us to understand why the uptake is lower in areas where one would expect it to be higher. I suspect that other witnesses who come before this committee might be closer to community pharmacy colleagues in terms of understanding the day-to-day pressures that they are under and what drives uptake. It may be that the patients do not come forward, or are not encouraged to do so, or the pharmacists may be in less of a position to encourage them because of other pressures that they face. I found the paper from England interesting, and Public Health Wales would be interested in doing a little more work on whether that pattern is also seen in Wales. The English paper suggested that issues related to whether the pharmacy was part of a multiple or individual contractor, and issues related to the pharmacists, were driving the trend there. I cannot tell you what the situation is in Wales, because we do not have an evaluation of it.

[29] **Vaughan Gething:** That effectively goes against what we were told by the community pharmacists. They gave us the impression that they are able to engage in a range of different communities, and were successful in doing so because they are community pharmacists. You are telling us something different: that that is unlikely, based on the study in England. It would be useful to have had this evidence then, so that we could have questioned the community pharmacists on it. I wonder whether we can go back to them and say that this point has been made to us, because it is not in line with what they said.

[30] **Ms Hinchliffe:** It is interesting that there seems to be a difference between MUR services and pharmacy services in general. It certainly is an issue of community pharmacy being more accessible in more deprived areas. We did a little exercise where, based on information on deprivation that is collected across Wales, each area was put into one of five categories: category 1 is the least deprived, while category 5 is the most deprived. Based on the postcodes of community pharmacies, we assigned a category to each community pharmacy. There are nearly twice as many pharmacies in deprivation area 5, the most deprived area, compared with deprivation area 1, the least deprived. The same trend emerges when comparing areas 2 and 4. There are significantly more pharmacies in more deprived areas. Issues related to how contractors choose an area and how community pharmacy funding works lend themselves to putting community pharmacies in more deprived areas, because of the volume of prescriptions historically and the way that they are paid for. There are some positive aspects of where community pharmacies are sited if you want to address inequalities issues. However, it seems that there may be a slightly different situation with MURs; we need to understand that difference.

[31] **Kirsty Williams:** Should we really be surprised by what has come out of the English paper? Is this not another example of the inverse care law? The people who need the service most tend to be those who do not access the service. That is mirrored through all of our screening programmes; the very people who need access most are the least likely to get it. It is the worried well and people who have the resources who are most likely to avail themselves of these things, such as Vaughan availing himself of a review or me availing myself of a minor injury scheme. This is just another example of that, is it not?

11.15 a.m.

[32] **Ms Hinchliffe:** This is a difficult issue. I can think of reasons why that might happen,

but I would be speculating. In representing Public Health Wales, I am trying to give you evidence rather than my personal views and speculation about why this might be the case. There are a number of reasons.

[33] **Elin Jones:** I also have a question on this point. In your paper on MURs, you say that you have local authority data on the use of MURs by community pharmacies, and that the range varies quite significantly, from 27 per cent to 60 per cent. Could we see those local authority data, to see where the lowest use of MURs has been, and whether there is a correlation between those local authority areas and the local authority areas that tend to have the most significant deprivation issues?

[34] **Ms Hinchliffe:** We have that information but I do not have it with me this morning. However, we can certainly get it to you.

[35] **Rebecca Evans:** Could you tell us more about the recent Public Health Wales report on health literacy, and what your recommendations would be in terms of addressing the issues raised in it?

[36] **Ms Hinchliffe:** From a pharmacy perspective, one thing that we have come to realise is that it is very important that people understand how to use their medicines. We used an American study, so apologies for that. It looked at issues such as whether people understand what is meant when they are told to take medicine on an empty stomach—only about 40 per cent of people knew what that meant. Similarly, it looked at where people were told that they had to take two tablets in the morning and two in the evening and were then asked how many tablets they would be taking in the course of the day. A significant number of people could not show that they would be taking four tablets. A lot of work has been done to highlight the fact that waste is an issue and so forth. In pharmacy, we are interested in whether it is possible to support health literacy initiatives to try to encourage people to take their medicines better and to get more benefit from them. As pharmacists in Wales, we tried to contribute to the Public Health Wales report that came out, using examples supplied by pharmacists in every health board in primary and secondary care across Wales of things that they were doing to try to improve health literacy. They showed how they were trying to ensure that people had greater knowledge about their medication, that they could apply that knowledge, that they knew where to go to obtain more information about how to improve their health, and that they knew how to use it.

[37] We are now looking at some of the recommendations in the report. How do we build health literacy awareness into the work of all health professionals? In respect of pharmacies, we have been looking at how we make our colleagues aware of the importance of helping people to understand their medicines, to manage minor ailments and to carry out self-care. These are issues that are of a health-literacy nature that are linked to pharmaceutical services and the taking of medicines.

[38] **Rebecca Evans:** I was very interested in the comments that you made in your report about the minor ailments service, and whether it might undermine Government attempts to encourage people to self-treat. I was really surprised that a third of consultations were for head lice. Perhaps this comes back to what was said earlier about people who already have some awareness seeking extra support and advice. What would a good minor ailments scheme look like, and how could it make the best use of available resources and expertise?

[39] **Ms Hinchliffe:** In deciding what you want a minor ailments scheme to do, you have to be clear as to its objectives. In listening to the debate on this, I have picked up on two lines of argument. The first states that when people have their minor ailments managed by a GP, it is an inappropriate use of GP resources. If these ailments were managed by another health professional, it would free up time for the GP to manage more complex patients.

[40] That line of argument used to be based on an acceptance that we will be managing people on the NHS for minor ailments, but that is just a question of which health professional we use. The other line of argument is that we want people to manage these conditions themselves, without needing the NHS. The results of the Welsh health survey 2010 are interesting; it asked people, 'Have you been into a pharmacy in the last four weeks to buy some medicines?', and 36 per cent of people said that they had. So, there are a significant number of people who are already managing by purchasing their own medicines. The question then is: are we, with the strategy of having a minor ailments scheme, to try to encourage more people down that route of being able to manage without needing to have minor ailments treated on the NHS, trying to better equip people? Looking at some of the studies that have been done on minor ailments, there does seem to be a number of reasons why people go to a GP about minor ailments. It is often cited that people want a prescription to get their medicine free, whereas otherwise they would buy it over the counter. When people are questioned about that, it does not tend to be the No. 1 reason why they say that they go to the GP. There tend to be many more issues around having reassurance and feeling confident that the GP has checked that there is not anything seriously wrong with them. Not being sure about what the problem is and how to manage it seems to be the issue.

[41] If you had a minor ailments scheme that is just about transferring people from one NHS provider to another, I guess it would be about having a supply function. If you want a scheme that encourages people to be more competent to manage things on their own, and to increase people's health literacy in this area, in the longer term, you may consider establishing a scheme in certain areas where this particular issue exists, or you could try to identify the topics where there seem to be some gaps. I think the Neath Port Talbot scheme, for example, showed that head lice and the management of temperature were particular issues. A lot of it was to do with small children. Should we be more proactive about how we help people to know what to do if their child has a temperature, and when they can manage that on their own and when they would need to seek additional NHS care? Maybe we need to think about why people need to use the system for head lice. It could be that head lice are head lice and they spread as children mix in school. However, maybe there are issues around the fact that some people do not realise that when you use the treatment for head lice, you need to use a lot of them again seven days later, so that if you had any eggs that have now hatched, you can catch them. If you do not do that again seven days later, you are in a cycle. Is it just about supplying medicines to people or is it about trying to use that supply to increase people's health literacy, and to make a difference in the future?

[42] **Kirsty Williams:** Is one of the other areas about access?

[43] **Ms Hinchliffe:** Access?

[44] **Kirsty Williams:** Yes. Is it a case of, 'I've got a bad chest, I cannot get to see my doctor, but I could get to see a pharmacist today and maybe have something for my bad chest'? One of the crucial elements, from a patient's perspective, is ease of access to someone.

[45] **Ms Hinchliffe:** Yes. If we had a system where people were managing to look after some of the more straightforward-to-manage minor ailments, maybe that would free up capacity in the system for people such as you, when you are more unwell and are more in need of seeing a health professional, because it is not something that you can manage on your own.

[46] **Kirsty Williams:** I just want to see someone quickly. *[Laughter.]*

[47] **Mark Drakeford:** Darren, do you have a point on this?

[48] **Darren Millar:** I just wanted to pick up on the reference that you made to free prescriptions. You cite 2008 research in your paper, which concluded that,

[49] ‘Users’ strong preference to see a GP, coupled with the availability of free prescriptions in Wales may, however, conspire against achieving these policy aims.’

[50] The policy aims in question are to shift people to a community pharmacy from a GP surgery. That seems at odds with what you have just said, that is, that people do not just go to see their GP to access a free prescription. Can you clarify the position on that?

[51] **Ms Hinchliffe:** Some people do visit their GP for that reason. A number of people have looked into this area and I can send more references to you, if you are interested in that. It is a factor, but often it is not the main factor for people. In one report that I saw, about a third of people said that it was a factor for them. However, we are not saying that 100 per cent of people—

[52] **Darren Millar:** It is a significant proportion, however, is it not?

[53] **Ms Hinchliffe:** Yes, it is a significant proportion, but—

[54] **Darren Millar:** Whenever I have been to a pharmacist to ask for some advice, they have tended to want to sell me the most expensive product on the shelf to deal with the complaint that I have presented. As it is a business, there is an element of people mistrusting the advice that a pharmacist might give because he or she may want to make the biggest profit possible from the person presenting at the door. Is that a factor? Is that something that is cited as a reason why people avoid going to a pharmacist?

[55] **Ms Hinchliffe:** That is not something that I have come across in the papers that I have seen.

[56] **Darren Millar:** It is just me. [*Laughter.*]

[57] **Kirsty Williams:** They see you coming, Darren.

[58] **Mick Antoniw:** In paragraph 2 of your paper, you refer to efforts to minimise bureaucracy and burdensome accreditation. That is a phrase that always concerns me whenever I see it, particularly with developing areas of work. What are the bureaucracy and burdensome accreditation that you are primarily concerned with? Can you give me some examples of the problem?

[59] **Ms Brennan:** I think that Community Pharmacy Wales referred to this in its response as well, and Russell Goodway gave some good examples of the frustrations that community pharmacists face with some of the burdensome paperwork. No pharmacist will ever argue against the requirement to undertake any accreditation that ensures their competence in delivering the clinical elements of a service—we would not argue with that. However, often, pharmacists are asked to complete numerous forms in triplicate or duplicate and there are no easy procedures for returning that paperwork to the health board.

[60] In services such as enhanced services, where pharmacists are able to provide prescription-only medicine, in the way that Kirsty referred to their being clinically competent to do, they have to undertake accreditation in order to deliver the medicine under what is called a patient group direction. The actual interpretation of the patient group direction is often the same in terms of the process, regardless of what the medicine is, yet pharmacists are required to attend another training course in order to operate another patient group direction.

There is an increased demand on the pharmacy profession, often self-imposed because, in the past, the Royal Pharmaceutical Society has been quite stringent with regard to the requirements for pharmacists to continue to jump through these hoops every time. You would not make those demands of a medical professional; you would not require a GP to go through what is largely a process-driven accreditation rather than a clinically driven one.

[61] **Mick Antoniw:** I am not sure that that is necessarily correct. It seems to me that there may well be very good reasons for having to complete documentation. We are in an area where it is important to be concerned about the quality of the service and the potential for error, including a lack of link-up with GPs and so on. Are you really saying that we should have a streamlined system of accreditation, qualification and so on? If so, what should that be? What format should that take? At the moment, every time I see one of these papers, people are saying, 'If only I could get rid of the paperwork' or referring to problems with accreditation, diplomas, qualifications and so on. However, there are real issues to do with quality and I would have certain concerns. I am interested in how you would make that better, more effective and streamlined, rather than just how you would get rid of it. Do you have any views on how that might be achieved?

11.30 a.m.

[62] **Ms Brennan:** First, I would wholly support what you have said around streamlining the way that that accreditation can happen, as well as the recording of any necessary information. I absolutely agree with you; nobody is asking to cut corners here. However, what we do need is some way of making that happen. I am not sure that I have the answer for you today; I can come back to you having given it some thought, if you like. There is an inconsistency in that, every time we develop a new service for community pharmacy, it appears that the amount of paperwork that goes with that is burdensome and distracting, potentially, to somebody on the front line delivering a clinical service. That is what pharmacy is raising as an issue here: how do we minimise that, but not to the degree where we compromise patient safety in any way?

[63] **Mick Antoniw:** Should there, therefore, be a community pharmacy qualification that identifies all the different categories of enhanced service, and which is above and beyond the normal pharmaceutical qualifications that you would expect?

[64] **Ms Hinchliffe:** When I made that statement about whether it is burdensome, what I partly had in mind was a situation where you would have different health boards delivering a service that was pretty similar. For example, prior to the national emergency hormonal contraception service, you might have had several health boards running that sort of service in a slightly different way; you might have a locum who was doing work for Hywel Dda Local Health Board and Cardiff and Vale University Local Health Board, for example, and they would have to go through the accreditation process in these different health boards to do essentially the same thing. It has been recognised that that is burdensome, and that there should be a way of getting accredited once to provide a service that is essentially the same across different health boards. The Wales Centre for Pharmacy Professional Education is getting involved in this now, so increasingly there will be areas where people are accredited through WCPPE on behalf of the health board. WCPPE will work with the health boards on accreditation, and if you have been through that, you will be deemed to be accredited for all the health boards. That is one way that things are developing in this area.

[65] The other thing that is interesting is ensuring that services are only provided by people who are accredited, in accredited pharmacies. Some of the IT systems are able to ensure that people are only able to make claims for providing services if there is a cross-match in the computer system that indicates that that person has the necessary accreditation. There is some movement in that area. We are trying to get better at it, but we are not

completely there yet.

[66] **Lindsay Whittle:** I wanted to come back to these medicines use reviews. I do not see the point in the anonymity of it because if someone has been on anti-depressants for 10 years, clearly they are not working, are they? You, as pharmaceutical professionals, need to get that information back to a GP who may be very busy, and who may automatically sign the repeat prescriptions—I do not know, but that is what I fear happens a lot. What can we do to remove that anonymity? I think that it is very important.

[67] My second question might be difficult for you to answer. Have you ever thought about alternative medicines and more natural therapies, or is that against your faith?

[68] **Ms Hinchliffe:** In terms of the anonymity, we are trying to make a distinction between the professionals who are involved in direct patient care, who clearly need to be able to see patient details and be able to identify people—they obviously need to see that information—and people like Nuala and me. We might be involved in the evaluation of some of these services at an all-Wales level, and clearly it would be inappropriate for us to be able to see individual patients' details. We do not need to see them; it has no relevance to the way that we work. However, we would like to be able to see some information that would help us to identify, for example, which health board someone was in, whether it was a rural or urban area, whether they were in deprivation quintile 5 or deprivation quintile 1, and maybe which drugs were identified as being issues, and what intervention or recommendation was made. We think that it would be possible to do that, but when you are making agreements with contractors about the service, you need to plan these things, and we are just getting much more aware that we need to plan for the information that we want to gather if we want to be able to evaluate things later. In terms of the anonymity, it is not to do with direct patient care. The reason we would not want to be able to see the information at a Public Health Wales level—

[69] **Lindsay Whittle:** With respect, I was not asking whether you see the patient's personal health record. Most of us go to the same chemist every time we collect our monthly prescriptions. I know my chemist personally. I have had a medicines use review and it was good and useful, but I am sure that pharmacists see some patients and say to them, 'I think this drug is not working on you.' While they tell the patient that they need to go back to their GP, that patient has probably become reliant on that drug and should not be on it.

[70] **Ms Hinchliffe:** It is difficult. We need to make a distinction with regard to the MUR, as is really about exploring issues of adherence and how people are getting on with their medication. It is not a clinical medication review, which is something for a GP or other clinicians to do. Once you start getting into issues of whether a drug working for somebody, you may identify that issue, and you may encourage the patient to go back to their GP and talk about it, but it is not a role for the pharmacist under the MUR to get involved in that level of detail. The MUR is more about trying to understand people's adherence issues.

[71] **Lindsay Whittle:** What about alternative medicines?

[72] **Ms Hinchliffe:** That is interesting. Personally, I have looked at it, because of my training. I do not know whether you know, but Wales is the centre for alternative medicine information queries across the UK. So, any pharmacist who has worked in medicines information at the University Hospital of Wales will have dealt with alternative medicines. There are different regulations for alternative medicines than for more traditional medicines, with regard to the amount of evidence you need to demonstrate that something works and the whole licensing process.

[73] **Rebecca Evans:** I would like to make a point, so that it is on the record. If someone

has been on anti-depressants for years and they are maintaining a family life and have employment, the drugs are probably working. It is just worth putting that on the record.

[74] **Mark Drakeford:** Just one quick question from me, probably the last one. I was slightly surprised at the rather sceptical note your paper struck about the potential for community pharmacy to make a larger contribution in future to the NHS in Wales. Am I right in thinking, from the evidence this morning, that that scepticism is more about saying to us, as a committee, that if we thought that community pharmacy might have a larger part to play, we need to be clear in our minds about what we think that part would be, and to be aware that there are some evidence gaps in supporting some of those paths? Is that a fair summary?

[75] **Ms Hinchliffe:** I think that is fair; you have summed that up well. We have to be careful that we do not say that, because there is no evidence of something, it is proof that it does not work. Increasingly, we realise as a profession that we need to be better at gathering our evidence. You can end up in a bit of a circle, where you do not do anything because you do not have evidence, when in fact, we need to be doing something; we need to be looking at how we will be able to evaluate that, and getting our evaluation planned at the outset, so that, in five years' time, we would be in a different position if you were to hold your inquiry again. We would be able to show much more clearly that, if you do this or that, this is the benefit, and we would be able provide you with supportive evidence for some things. Just because we cannot provide evidence that something works, that does not mean that it does not work.

[76] **Mark Drakeford:** I have one last point, which is taking up a point that Darren asked you about earlier. You cite evidence that patients, when asked, say that they would rather go to their GP. Ought we in any way to be surprised at that, given that this was a prospective question? That is, 'If you were in the future to...would you rather this or that?' Was that not what everybody said about practice nurses, namely that they would much rather see a GP—'I'm not going to see that practice nurse'. It is a matter of education, is it not? Once the service is there, people are much more ready and willing to use it than they would be in theory and in prospect. Is there any evidence from places where minor ailment schemes have been on offer that people have then declined to use them? That is not a prospective question, because the service is in place. Is there evidence in those circumstances that people say, 'I'm not willing to use that minor ailments scheme; I'm determined to see the GP'?

[77] **Ms Hinchliffe:** I have read things about this, but I cannot give you the figures off the top of my head. However, from what I recall, you will get some people who will still say, 'I want to see my GP', but a large proportion of people will say that they will go to their pharmacy. It depends a little on how you frame the question, because people might say that they are happy to see their pharmacist about certain conditions, but they may have thresholds and say, 'But when it's about that, I'll want to see my GP'. So, it is sometimes quite difficult for people to answer the question about whether they would want to see a GP or a pharmacist without being given a scenario.

[78] **Darren Millar:** I just want to check something on that, because this is an important point. With regard to the respondents to the survey in 2008, it would be interesting to see whether they were interviewed before or after a consultation with their GP or pharmacist. If people express a choice before a consultation, then they will of course say that they would rather see their GP, or the top consultant for a particular ailment, as the Chairman rightly pointed out. However, if you put the question to people who have deliberately gone to the pharmacist, that is, why they have gone there rather than to their GP, then you will get a more potent response that we need to take note of. You have a link in your paper to the research, but is there any other research that we, as a committee, might consider looking at that will point us in the direction of why people make such choices?

[79] **Ms Hinchliffe:** Yes, there is other research, but it might be better if I gather some

things and send them to the committee, rather than trying to do it off the top of my head.

[80] **Darren Millar:** Thank you; that would be really helpful.

[81] **Mark Drakeford:** Thank you for your evidence this morning. We have all enjoyed it and learnt a lot. You have a couple of minutes now to tell us about anything that we have not asked you that you think we ought to be aware of, or to make any points that you want to make sure that you leave in our minds.

[82] **Ms Hinchliffe:** I have a couple of points. The first is that we think that NHS services need to be developed in response to identified needs and that the services offered need to be evidence-based—and that would apply across the board, not just for pharmacy. It could be that you need to gather more evidence for such an evidence base. Part of that means that we would want the adequate evaluation of services to be planned at the outset. Community pharmacy has the potential to be an integral player in the provision of NHS services and should be included as one of the options when health boards are considering how best to meet the needs of their population. Appropriate governance needs to be in place, particularly when pharmacists move into novel roles in delivering new services. We have not mentioned it already, but we would like to raise for your consideration the issue of whether there should be patient registration to ensure that the effectiveness of pharmaceutical care to patients with chronic conditions can be addressed. Finally, I would like to thank you for this opportunity to provide evidence.

[83] **Mark Drakeford:** Thank you very much for that and for your offers of providing some additional information to us as a result of this session, which will be helpful to us.

11.43 a.m.

Papurau i'w Nodi Papers to Note

[84] **Mark Drakeford:** Mae llythyr gan Gadeirydd y Pwyllgor Deisebau ynghylch deiseb P-03-292 ar ddarparu toiledau cyhoeddus. Mae'n siŵr bod aelodau'r pwyllgor yn cofio inni dderbyn cyngor yr wythnos diwethaf fod gennym amser yn syth ar ôl egwyl y Nadolig, yn ystod yr wythnos gyntaf, i wneud rhywbeth byr a chyflym yn y maes hwn. Felly, a oes unrhyw wrthwynebiad i'r syniad o wneud rhywbeth yn gyflym ar hyn am ddiwrnod ar ôl egwyl y Nadolig? Gwelaf nad oes, felly yr ydym wedi cytuno i wneud hynny.

Mark Drakeford: We have received a letter from the Chair of the Petitions Committee regarding petition P-03-292 on the provision of public toilets. Members of the committee will likely remember that, last week, we received advice to say that we have time in the first week following the Christmas break to do a short piece of work on this matter. So, are there any objections to doing something quick on this for one day after the Christmas break? I see that there are none, so we have agreed to do that.

[85] Finally, Members will remember that we have been consulting on terms of reference for our intended inquiry after Christmas into residential care. A paper will be distributed to you on Monday, which will outline some of the responses that we have had to that consultation. We will then come back on Thursday of next week to finally confirm the terms of reference. I just want to alert you to look out for that paper. Diolch yn fawr iawn.

*Daeth y cyfarfod i ben am 11.45 a.m.
The meeting ended at 11.45 a.m.*

