



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

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

Dydd Iau, 24 Tachwedd 2011
Thursday, 24 November 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
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
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**

Malcolm Clubb	Uwch Fferylllydd Polisi a Datblygu, Fferyllfeydd Cymunedol yr Alban Senior Policy and Development Pharmacist, Community Pharmacy Scotland
Alex MacKinnon	Cyfarwyddwr yr Alban, y Gymdeithas Fferyllol Frenhinol Director for Scotland, Royal Pharmaceutical Society
Elsbeth Weir	Pennaeth Polisi a Datblygu, Fferyllfeydd Cymunedol yr Alban Head of Policy and Development, Community Pharmacy Scotland

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

Stephen Boyce	Y Gwasanaeth Ymchwil Research Service
Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

*Dechreuodd y cyfarfod am 9.29 a.m.
The meeting began at 9.29 a.m.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da, a **Mark Drakeford:** Good morning, welcome chroeso i'r Pwyllgor Iechyd a Gofal to the Health and Social Care Committee. Cymdeithasol.

9.29 a.m.

Ymchwiliad i'r Cyfraniad a wneir gan Fferyllfeydd Cymunedol i
Wasanaethau Iechyd yng Nghymru—Tystiolaeth gan Fferyllfeydd
Cymunedol yr Alban a Chymdeithas Fferyllol Frenhinol yr Alban
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Pharmaceutical Society Scotland

[2] **Mark Drakeford:** Welcome to you. I hope that you are able to hear us at the other end of the video link. I see that you can. We can see and hear you, so it is quite a triumph for the technology so far. Thank you for joining us to help us with our inquiry into the potential contribution that community pharmacy might make to the health services in Wales. I hope that you are able to see all of us, more or less. As there are no nameplates in front of you, it would be helpful if you could briefly introduce yourselves so that committee members know who we will be putting our questions to. Elspeth, I think that we can guess that you are in the middle. [*Laughter.*]

9.30 a.m.

[3] **Ms Weir:** I am Elspeth Weir. I am head of policy and development at Community Pharmacy Scotland, which I have worked with for a number of years. I have been involved in the development of Scottish contracts since the first meetings that we had on that.

[4] **Mr Clubb:** My name is Malcolm Clubb. I also work for Community Pharmacy Scotland. I previously worked for an NHS board. I moved from the NHS to Community Pharmacy Scotland about three-and-a-half years ago, and I have been involved in the development of some services since I started there.

[5] **Mr MacKinnon:** Good morning, everyone. I am Alex MacKinnon, the director for Scotland for the Royal Pharmaceutical Society. I also used to work for Community Pharmacy Scotland, and worked very closely with Malcolm and Elspeth, especially Elspeth, on the development of the first part of the new community pharmacy contract.

[6] **Mark Drakeford:** I will just explain the format that we will follow for the next hour. I will ask you in a moment whether you have any brief opening remarks to make. We have had your written evidence—thank you for that—but if there are any particular points that you would like to draw attention to, there will be a chance to do that at the very beginning. Then, members of the committee will have questions for you. Given that we have only an hour, we probably will not be able to ask all three of you to answer every question, so we might see, every now and then, whether one of you wants to concentrate on replying to a particular point.

[7] We are coming to the end of our evidence taking for this inquiry, so we have already heard from quite a wide range of voices in Wales. Quite regularly during our evidence taking, witnesses have pointed to the experience that has developed in Scotland and have told us that there are useful things that we might learn in Wales from the way that things have developed

with you. So, we are very keen to make maximum use of the time that we have with you in order to learn from your experience so that we can start to think about how that will inform our thinking here. So, would anyone like to lead off for a couple of minutes?

[8] **Mr MacKinnon:** I will start by saying a few words, if you do not mind. The direction of travel for pharmacy, especially community pharmacy, came out of devolution, and it was recognition of the need to put the patient first. It is about patient care. That evolved into 'The Right Medicine: A Strategy for Pharmaceutical Care in Scotland'. The key difference in the approach taken in Scotland was that the patient was put at the centre of things. In effect, it moved the key performance indicator away from prescriptions to delivering care for patients. We were able to use that as a platform to develop services that are negotiated nationally and delivered locally. I believe that the core contract has enabled us to establish a platform on which the role of pharmacists can be taken forward further in future as clinicians and public health practitioners, and as prescribers. So, that came out of our original strategy around improving health and it came out of devolution. It has been an exciting and rewarding decade in which to be part of this work.

[9] **Ms Weir:** I would like to make a brief statement, which follows on from what Alex has said. We have already provided you with a written submission about the contract in Scotland. We hope that you found that helpful and we will do our best to answer any questions that you might have. We think that we have seen considerable progress in community pharmacy in Scotland over the last 10 years. Anyone visiting a community pharmacy here now would see a big difference compared with how it was a few years ago. However, we are very conscious of the fact that there is a lot more to be done. We cannot afford to stand still and we need to think about how we continue to shape services to deliver for the people of Scotland in the future.

[10] **Mark Drakeford:** I will turn to members of the committee now, who have questions. Each member of the committee might have two or three questions in a run, and then we will move to someone else. I will introduce people to you so that you know who the person asking you a question. I will start with Lindsay Whittle, who is a Plaid Cymru member of the committee.

[11] **Lindsay Whittle:** Good morning. Thank you for your evidence and for sparing us the time to be here this morning. What is the rationale for the four core services provided and how effective is that? However, I am more interested in any locally negotiated additional services that you offer.

[12] **Mr Clubb:** I will give you a quick overview of the four services. The chronic medication service is the latest that we have introduced, which has been operational for the last six to 12 months. It is designed to try to support people with long-term conditions who have multiple medications or are more likely to require more input from a pharmacist regarding their medicines. That is a key service that we expect to roll out much more aggressively over the next 18 to 24 months. That is really key, because most of the money spent in the area of primary care is spent on medicines, and we have to make sure that patients take them appropriately, that we minimise their side effects and prevent problems for patients to make sure that they get the best out of those medicines. There is no point investing in medicines without making sure that patients get the best out of them.

[13] The nationally negotiated minor ailments service allows for the current conditions of patients who were previously exempt from prescription charges in Scotland to be reviewed by a pharmacist. Pharmacists have several options: they can refer the patient back to a GP if they believe that the GP's input is required, or they can prescribe certain pharmacy-only or general sales list medicines to the patient on the spot, there and then, to allow the patient to be looked after or treated appropriately. Such common clinical conditions regularly managed by

pharmacists include pain, head lice and thrush.

[14] The public health service is all about a campaigning approach. We have several campaigns running in community pharmacy. In the coming weeks, flu vaccinations will be advertised in every community pharmacy. Pharmacists will recommend that patients appropriately get their flu vaccination. We will then run the be ready for winter campaign for six weeks over Christmas. That is about making sure that people have medicines available in the house if there is no GP available over Christmas and the new year. We make recommendations that people order their prescription on time to make sure that they do not leave it too late before Christmas. At the beginning of the new year, we will move on to the FAST campaign, which is the identification of stroke. That campaign is about looking for symptoms of stroke and referring patients accordingly.

[15] We are also lucky enough to have two patient services. The patient services that we currently have in operation are smoking cessation and emergency hormonal contraception. Every patient who smokes and wishes to give up can attend a community pharmacy and receive a 12-week course treatment using nicotine replacement therapy prescribed and supported by pharmacists to help them get to the point of quitting. Emergency hormonal contraception is available to patients who require that service.

[16] We are awaiting a public health service review report, which will probably be published in the next few weeks; we can send that on to you. It will focus on patient outputs and how patients value these services in community pharmacy—access being the key issue.

[17] The final service that we mention in the submission is the acute medication service. That is, basically, about electronic prescriptions, which I presume you already have in Wales with barcoded prescriptions and so on. That is not much different to what you do—it is just about the routine dispensing of prescriptions, as required, for patients.

[18] You obviously want to talk about local services as well. Historically, local services have been provided in conjunction with community pharmacy for things such as oxygen. There is supervision and dispensing of methadone and needle exchange. We also have a care home service, which looks at the safe storage of medicines in a care home. Is there anything else?

[19] **Ms Weir:** The only other areas covered are aspects such as the return of waste medicines to pharmacies, rota services and collection and delivery for people who live in remote and rural areas. The interesting thing about these services is that they were initially negotiated nationally and then taken out of the national contract and devolved to the local area, because some health boards need these services more than others.

[20] With regard to other additional services, although we do not flag them as such, the health boards have the opportunity to develop new ideas in their areas. In fact, the smoking cessation and EHC services started at health-board level and were then taken up and put in to the national contract.

[21] **Mr MacKinnon:** In addition to that, we introduced a national pharmacy patient group direction for out-of-hours services, which I thought was very innovative. When a patient's GP is not available—out of hours, on Saturdays and on bank holidays—the urgent supply PGD enables a pharmacist to prescribe a full cycle of a patient's repeat medication or medications, including virtually everything on the prescription authorisation form apart from controlled drugs and injections. This makes a major difference to access for patients when GPs are not available. Part of that was the ability of community pharmacists, as well as doctors, to directly refer patients to the emergency out-of-hours centres. That was very much welcomed by patients. In the eyes of patients, it got pharmacists prescribing, because they

were able to prescribe the medication that the patient had run out of.

[22] **Lindsay Whittle:** That was a comprehensive reply; thank you. I do not think that any of you took a breath.

[23] **Mark Drakeford:** The next question comes from William Graham, who is a Conservative Party representative on the committee.

[24] **William Graham:** Despite my surname, I am a sixth-generation Welshman. I will focus on the problem of rurality, as I have seen what you have written on this issue in your submission. The committee has heard evidence from the Dispensing Doctors' Association and the British Medical Association expressing concerns that the development of community pharmacies may undermine the viability of dispensing rural practices. Would that be your experience?

[25] **Mr Clubb:** That is a difficult issue to discuss. In Scotland, over the last couple of years, several dispensing doctor practices that were doing a high volume of prescriptions and pharmacists have applied to open pharmacies in those rural areas. Some of those requests have been successfully granted. To our knowledge, there is no evidence that any of the dispensing doctor services have been reduced or altered. We have to remember that the general medical services contract clearly sets out a funding stream for GPs, and talks about their global sum and their quality and outcomes framework. It is written in the regulations in Scotland that dispensing doctors are only asked to dispense when a health board is unable to get an adequate service to ensure that medicines are supplied to their patients. There are places—the isles of Scotland, such as Shetland, and places like Stornoway and so on—that are much more rural in nature, and we do not expect pharmacies to open in those areas. Despite the fact that we have a new contract, it would not be viable for a pharmacy to open in some of those small places. You probably need in the region of 1,500 people in an area to make it viable for a pharmacy. If the dispensing GP's list has fewer than 1,000 people on it, there is a good chance that it would not be viable to have a community pharmacy in that area.

[26] **Mr MacKinnon:** When you look at when the new pharmaceutical care services were introduced through the Smoking, Health and Social Care (Scotland) Act 2005, one of the primary intentions was to make the full pharmacy service available to as many people in Scotland as possible. However, we recognise that there are remote and rural areas where that is not possible. We support doctors being able to dispense in those areas.

[27] **William Graham:** Thank you for that answer. Has electronic transmission of prescription been helpful in rural areas?

[28] **Mr Clubb:** We have a slightly different system in Scotland. The patient has a prescription, which they take to a pharmacy. We pull down the relevant information through a barcode. I am not sure how the system works in Wales, but in England the information is pushed; the GP asks the patient where they want to go for their prescription to be dispensed and it is then pushed to the location of dispensing. I am not sure how it works in Wales: whether it is similar to England or whether the patient must go off with the prescription.

[29] **William Graham:** The patience has a choice here.

[30] **Mr Clubb:** In rural areas, if you have a pharmacy, you have a pharmacy. I used to work in a rural area; I worked in Eyemouth on the Scottish borders, which is a small fishing town. They would probably dispute that it is a small fishing town. We had one GP practice and one pharmacy. That is a common system in Scotland. You will see most of the patients—97, 98, or 99 per cent of patients will come to you for their dispensing services in that kind of one-to-one relationship. In rural areas, the services that are provided are not different to the

services that are provided in urban areas.

9.45 a.m.

[31] **Mark Drakeford:** I will turn to Rebecca Evans, who is one of the Labour members of the committee.

[32] **Rebecca Evans:** Can you talk us through the ways in which the services of community pharmacies are integrated with wider health services, and how you avoid duplication and the fragmentation of services?

[33] **Ms Weir:** We have tried to look at how community pharmacies can be used in ways that are appropriate within the NHS, trying to get patients treated in the right place at the right time. We are looking to make services accessible. Community pharmacy is positioned throughout Scotland, so there is a network that is available to patients and the public to use. The main aim of using community pharmacies is to try to reduce pressures on other parts of the NHS. We have already talked about ways in which we are trying to do that. There is the minor ailments service and over 800,000 patients are now registered for that service. They can come in to see a healthcare professional and receive advice or treatment. There is the public health service, which Alex mentioned. We are also well-integrated with NHS 24, the telephone triage system, which uses community pharmacy as a major line of referral in the out-of-hours period. As Alex mentioned, there is also the community pharmacy urgent supply service, which allows the pharmacist to prescribe medicines when the patient has run out. As regards integration, the most important relationship is the one on the ground between the local GP and the pharmacist. That is where discussions have to take place.

[34] **Mr MacKinnon:** From the professional body point of view, we are working closely with the Royal College of General Practitioners to produce a joint statement of working together and engagement, which I am sure will help the process, as we take the contract and pharmacy services forward across primary care in the future.

[35] **Rebecca Evans:** What is the level of awareness among patients of the services that they can access at community pharmacies? How do you publicise those services?

[36] **Ms Weir:** Each pharmacy has a leaflet that details the services that are available and there is also signage in their windows that lists what the public can expect to receive in that pharmacy. People who use the service know what is available. There are still a lot of people who do not need to go into a pharmacy often, but, when they do, I am sure that the information will be available for them. Pharmacies are not allowed to advertise: they are not allowed to do leaflet drops about the services that they provide. Some of the health boards have promoted ideas, like the smoking cessation service, through adverts on buses and local radio. Pharmacy is routinely mentioned when there is discussion about the NHS.

[37] **Mr Clubb:** As regards the public health service campaigns, which I talked about earlier, posters pushing the minor ailments service appear regularly in the suite of posters over a year. We think that 33 per cent of people who are eligible for the minor ailments service are currently registered for that. However, it is a rolling registration: you register and lapse after one year if you have not been seen in the last year. Far more people who are eligible for it have been registered at some point, but they drop on and drop off as they use the service.

[38] **Mark Drakeford:** I will turn to Kirsty Williams, who is the leader of the Liberal Democrats in Wales and, more importantly, their health spokesperson.

[39] **Kirsty Williams:** Thank you, Mark, and good morning to you all there. I will pick up where we left off on the minor ailments service. The number of people who are registered is

impressive. We have received mixed evidence in this committee about the usefulness of a minor ailments service, in relieving pressure on other aspects of the NHS. Doubts have been expressed over whether that happens. Have you done any research that measures the impact of having people use the minor ailments service rather than going to sit in their GP's waiting room? Also, we have had some quite difficult evidence on the sharing of information between professional groups, especially between GPs and community pharmacies, suggesting that there is almost a reluctance among GPs to share such information. Based on your experience, how have you overcome professional boundary issues in relation to the sharing of information?

[40] **Ms Weir:** I will start and then I will pass this over to Malcolm. A research paper was published last year, titled 'Changing patient consultation patterns in primary care: an investigation of uptake of the Minor Ailments Service in Scotland'. This research was undertaken by the University of Manchester. I can send you a link to that report, if you would like. As we have said already, the minor ailments service is about treating people in an appropriate setting. Our minor ailments service allows the public to access advice or treatment quickly. We are not saying that we are freeing up time elsewhere by providing that service. What we are saying is that we are allowing people in other areas to use their time more appropriately. It would be very difficult to find evidence that this has saved the NHS money.

[41] Regarding the exchange of information, we do not exchange information for the minor ailments service because the products that are available are those that people could buy over the counter. However, for other services, we are working on this through the chronic medication service. Malcolm will expand on how information flows happen in that context.

[42] **Mr Clubb:** We are in a fortunate position in the chronic medication service. Since moving to having serial prescriptions available in the service, every time a prescription is dispensed for a patient, an electronic message is sent automatically to the GP practice, which then populates the patient's information. This is the first time that the GPs have had visibility on whether something has been dispensed or not. Historically, GPs may well have issued a prescription and had brilliant data on the fact that the prescription was issued, but they never knew whether the prescription had been dispensed. So, the patient could choose actively not to proceed with the medicine. Now, having a barcode on the medicine will allow a message to be fired to the GP practice, which will provide the GP with some comfort and knowledge of the fact that the prescription has been dispensed.

[43] We are also in a fortunate position in terms of the way the system has been set up within the chronic medication service. We are able to produce what is known as an end-of-treatment care summary. This is usable at any point, and a pharmacist can send a message like an e-mail automatically to a GP, using a limited list of characters, to inform the GP that they are concerned about a particular patient. Alternatively, at the end of a six-month serial prescription, they can send a message to say that the patient has turned up regularly and on time for their medication every month, that there are no issues to report with the medicine, and that they are quite happy to request a subsequent serial prescription. We have reached the point now where pharmacists are automatically sending information to GP practices.

[44] Conversely, it would be useful for us to have access to more information. As you can imagine, when you start having some information, you always want a little more. In my submission, I have mentioned issues like the fact that it would be useful for pharmacies to have things like cholesterol results. For example, a patient may have been on a statin tablet, and their cholesterol level has been absolutely fantastic while they have been taking 40mg statin tablets for the last two years. All of a sudden, however, a GP obtains a result, or a result is taken at a hospital outpatients' clinic, and the reading is 5.2. The question is: has the patient taken the medication every day, or has the patient been a bit slow in taking it, and therefore

not had the best benefit? The default position is often that the dosage goes up, although it would probably be more beneficial to spend a bit of time with the patient talking to them about the medicine, asking them whether they are taking it every day or having problems with it. That would be useful.

[45] Another patient safety issue is related to warfarin results. Currently, patients are expected to take a yellow book with them to the pharmacy when they are having warfarin dispensed. Patients are brilliant, but they do not always remember to bring their yellow books. Therefore, they are being supplied with warfarin tablets when it is possible that their international normalised ratio results or warfarin dosage are not known. Therefore, it would be really brilliant if we could see these results electronically, so that we would know whether an INR test had been done in the last couple of weeks and we would know what dosage the patient was taking. We could make sure that they had the right tablets in order to take the appropriate dose.

[46] On medicines reconciliation, I am glad to see that you have a discharge scheme in Wales, which I am really interested in. When patients are discharged from hospital, the community pharmacists are involved with medicines reconciliation. That is a really big role. Patients are often discharged on a Friday, a Saturday, or even a Sunday, because the pressure on acute hospital beds is such that patients are sent home whenever possible.

[47] Often, patients may have ordered medicines before they go into hospital. Those medicines will be made up in the pharmacy in advance of them coming in. If they come in on a Friday or a Saturday, having just been discharged from hospital, and we have no information about their discharge medicines, then patients could pick up medicines that they do not need, and that can create waste. The more information that you can give to pharmacists in those sorts of areas, the more that you will help to improve patient safety and decrease wasted medicines. That is key.

[48] **Mr MacKinnon:** I would just like to add one point about our minor ailments service. It was set up as a patient-driven consultation with pharmacists. It was an opportunity for patients to discuss issues in relation to minor ailments. It has established a platform that could be taken forward further in the future and expanded to include a wider range of common clinical conditions, as well as more patient-group direction for prescription-only medicines that could be used to treat some of those common clinical conditions. Another stage of development may be possible.

[49] **Mark Drakeford:** Before I turn to Mick, I will raise once point, Elspeth, on what you were saying. Another thing that has been suggested to us about minor ailments schemes goes a little bit like this: it has been said that, on the one hand, there has been a 10-year struggle in Wales to try to simplify messages to patients so that they know where to go for whatever condition they happen to have, so that they turn up at the right door—to make that a system that everybody understands. It has been suggested that a minor ailments system among community pharmacists would be the opposite to that, and that it would add a new level of confusion. People would not be sure about where they should go to get the treatment that they need. It could cloud the issue for patients, rather than making it easier for them. Do you have any thoughts on that? Have you had any experiences in Scotland that would help us to cast some light on that assertion?

[50] **Ms Weir:** One of the reasons why the minor ailments service was set up was to address health inequalities. People who have money and have a health problem can go into a pharmacy to buy a product over the counter. People who do not have the money have to go to a doctor to get a prescription to treat their minor ailment. By setting up a minor ailments service, we have been able to allow people to come into the pharmacy to access the advice and treatment that they need more quickly than if they had to wait for an appointment with the

doctor. Access is important. I do not think that it has been confusing for patients. Nurses in doctor's surgeries are now saying to patients that they would be better off going to the pharmacy. Conversely, if the pharmacists think that it is more than a minor ailment, they have the ability to refer the patient to somewhere else in the system.

[51] **Mr MacKinnon:** As Elspeth rightly said, improving access was the key driver for all of this. It has started to establish pharmacies as the first port of call for minor ailments. It will not be long before pharmacies are established as the first port of call for minor ailments, because it is working very well.

[52] **Mark Drakeford:** The next question will be from Mick, who is a Labour Member.

[53] **Mick Antoniw:** Going back to the pilot schemes that were set up, can you tell us a little about the strategy behind them, how they worked, what lessons were learned from the way in which they were carried out, and the role of the Scottish Government in controlling pilot schemes—as opposed to the local health board, or whatever?

[54] **Ms Weir:** I was involved with the project board for the pilot schemes. We ran them in two health board areas. Their primary drivers were to address inequalities and promote access. We had a steering group, and we obviously had project teams in each of the health board areas. We spent a bit of time at the beginning deciding which conditions would be covered and which products would be available, as well as working out the systems for prescribing medicines. Then, the project teams in each area set up their own publicity around the scheme and talked to the pharmacists in the area and briefed other health professionals in the area about what would be happening. Then, the services opened.

10.00 a.m.

[55] When we were setting this up, we were very conscious of the fact that, if we paid a fee for each prescription, we could be accused of offering perverse incentives. So, right from the very beginning, we were talking about having a registration system and payment by capitation. So, when we started out we had a paper-based system. As you might imagine, that created problems. So, we learned from the pilot schemes that we should have an electronic system for registration, which we could then use for the payments. We then developed the electronic system for the actual mechanism for prescribing.

[56] The other thing about the pilot schemes was that it very soon demonstrated to us that to price these prescriptions for products that were being supplied in small packs created problems for our pricing division. So, we had to take steps to correct these pricing anomalies as well. We learned a lot from the pilot schemes. Much to our surprise, we also learned that everyone did not suddenly rush in to register for the system; it built up slowly and gradually.

[57] **Mr MacKinnon:** Elspeth mentioned IT there. One of the key successes in this right from the beginning of the first set of pilot schemes has been that the core services have been underpinned by an appropriately nationally developed IT infrastructure, funded by the Scottish Government. That commitment was there right from these early pilot schemes and has continued right the way through all the different core services to the electronic pharmaceutical care review web-based plan that Community Pharmacy Scotland worked with the Government to develop. That must not be underestimated, because it allows us to electronically collect information that could be used very positively in future.

[58] **Mick Antoniw:** Who has control or ownership of the pilot scheme? Is this a Scottish Government-controlled project with the local health board? To what extent was that important or unimportant, a hindrance or whatever?

[59] **Mr Clubb:** My belief is that the Scottish Government controls the project. At the end of the day, the Scottish Government was responsible for delivering the IT solutions with the e-pharmacy team through the procurement of the IT system that was required for it. Therefore, the Scottish Government was the project owner. It was vital in working with health boards and primary care leads. I used to be a primary care lead in a health board. We needed the Scottish Government because it negotiated services nationally to ensure that the electronic underpinning, service specification, payment system and training from NHS Education for Scotland were in place to ensure that the pharmacists knew exactly what to do, what they were to be paid and that the service they were expected to provide was a national service.

[60] That means that we are in the brilliant situation where a patient can walk into a pharmacy in Wick or Troon and receive exactly the same service; it does not matter where they go. When it comes to the core services, like the split services we have, it must be the same whichever pharmacy you go to. It makes things much more difficult if people get different levels of service from health boards. Some people may well be registered with a GP in Lothian but use a pharmacy in the borders because it is only five miles over the hill. You have to look at these scenarios. Because Scotland is a small country, we need to ensure that the service provided is exactly the same wherever you go. That is why it is important that the Government takes ownership of whatever services it is decided should be delivered.

[61] **Ms Weir:** Going back to the beginning, the Government wanted to run a pilot scheme and invited the boards to express interest in running the pilot schemes. We picked the boards—Ayrshire and Arran and Tayside—to do it. In the same way, Ayrshire and Arran was picked to do the initial transfer of prescription information. So, the Scottish Government would write to the health boards to say that it had this idea, asking who would like to participate.

[62] **Mr MacKinnon:** From a national perspective again, throughout the development of contract services, the education and training of pharmacists and pre-registration students was supported and delivered nationally through NHS Education for Scotland. That aids the consistency of service delivery across all parts of the country; everyone is getting the same training, which has helped immensely.

[63] **Mark Drakeford:** We turn to Elin next and then Vaughan. Elin is the Plaid Cymru health spokesperson at the Assembly.

[64] **Elin Jones:** Good morning. You talked a bit about the use of electronic infrastructure to allow the transmission of prescription information between GPs and community pharmacies. I am interested in the sharing of patient records. Is there any ability currently to share patient records between GPs and community pharmacies? I would like to put the question in the context of the flu vaccine programme that you said community pharmacies were about to embark on in Scotland. We have received conflicting evidence in our inquiry in Wales as to whether there should be a roll-out of a full flu vaccine programme in community pharmacies in Wales, based on the question of whether community pharmacists would know for definite whether an individual going into a community pharmacy was in an at-risk group. Would the GP then have on a patient's record the information on whether that individual had received a flu jab in a particular year? I am interested in the flow of information on something like a flu vaccine back to the GP from the community pharmacist.

[65] **Ms Weir:** Traditionally in Scotland, the way that it has worked is that we have what we call a stock-order system, which allows doctors to order in bulk certain items from pharmacies. Each year, generally at the beginning, the doctor will order from the pharmacy sufficient vaccines to treat the patients that are identified as being in the at-risk groups of the practice. The pharmacy knows from year to year how many vaccines are normally ordered, so it can say to the doctor whether or not the order is enough and perhaps suggest that it should

be topped up. So, there is a good exchange of information there.

[66] Another thing that is done when the vaccine orders come in is that pharmacies have to tell the flu vaccine co-ordinators at the health board how many vaccines have been ordered, where the orders have been placed and where they have been split, to ensure that it is not all tied up in one manufacturer. So, there is information going to the boards about how many vaccines are ordered and how many for each practice, for example. All of that kind of information creates a database, so that we can know that we have the vaccines available to treat the people in the at-risk groups. The pharmacy, once the vaccines come in, will obviously then deliver them to the surgery for the practice to use when the patients attend.

[67] We had started initial discussions on a service where vaccination would be provided in the pharmacy on the NHS. However, we have been unable to put that in place yet, due to some legislative constraints.

[68] You asked about whether the pharmacy would know if a patient was in an at-risk group—

[69] **Elin Jones:** I misunderstood what you meant when you said that community pharmacies would be undertaking a flu vaccine promotion. I assumed that you had said that the community pharmacists themselves would be administering the flu vaccine, but that is not the case.

[70] **Mr Clubb:** I will add a little to that to give you a little more context. NHS Grampian and NHS Tayside are two health boards that currently allow community pharmacists to administer vaccines on occupational health grounds. For example, nurses from acute wards who get vaccinated by the NHS for occupational health reasons can now receive their vaccines in the community pharmacy. Social workers and carers can also receive the vaccine in those health board areas in the community pharmacy. Paper information is sent back by the community pharmacy to the patient's GP to say who they have vaccinated for occupational health reasons, but that is no different to what an NHS board's occupational health team would do. It would tell the GP practice, 'By the way, I have vaccinated this nurse, this out-of-hours GP, or whoever'. That information is shared with the pharmacy.

[71] You also want to look at the at-risk groups and how you identify an at-risk group. The chief medical officer letter, which comes out on an annual basis in Scotland—and I know that it does in England and presume that it does in Wales—lays out clearly who is in an at-risk group, for example, who has a cardiac condition that requires a flu vaccination or who has chronic obstructive pulmonary disease. If you are on medicines for COPD and asthma, you clearly fall into at-risk groups, and if you are on a beta blocker or an angiotensin-converting enzyme inhibitor, you are clearly in the cardiac patient group. Identifying those in at-risk groups should not be too difficult. We are really good at vaccinating over-60s, which is where we have good percentage hit rates of vaccination compliance, but we are not very good with the members of at-risk groups who may well be working. For these people, getting to the GP just for a flu vaccination is a bit more difficult. Therefore, we are not achieving the same level of uptake from those groups. One place that they come every month or two months at that time of year is their community pharmacy to pick up their medicines. So, it would not be a great leap of faith to jump to the fact that a community pharmacy could provide a service to patients who do not regularly have easy access to their GP due to the fact that they work during the week, and, for example, they could be commuting to Newport or Cardiff to work, so getting back to their GP within the right hours could be difficult.

[72] Our problem is that, legislatively, under the National Health Service Reform (Scotland) Act 2004, we cannot give vaccinations to those groups, because of GPs' access to that. Whether that is something that will change in the future, I do not know. The Scottish

Government has set itself quite difficult targets around the level of flu vaccinations among the at-risk groups and the over-60s. Year on year, it achieves the over-60s target, but we are not doing so well with the at-risk groups, so, perhaps something may have to change to ensure that the Government meet its targets.

[73] **Mr MacKinnon:** On the matter of access to electronic patient records, community pharmacists can access a patient's electronic record at the moment via NHS 24, although that can be a bit round-the-houses and laborious. However, in the Scottish Government's new e-health strategy for 2011-17, there is a commitment to make an up-to-date and accurate electronic medication record available to pharmacists by 2014.

[74] **Mark Drakeford:** I am optimistic that, before we finish at 10.30 a.m., there will be a couple of minutes at the end when, if there are issues that we have not managed to touch on in the questions or key points that you think have not emerged strongly enough in our discussion, you will have an opportunity to come back and draw those to our attention. We will go to Vaughan Gething next, who is a Labour member of the committee.

[75] **Vaughan Gething:** I am interested in the chronic medication scheme that you run and a couple of aspects of it. One is the registration requirement, because you said that this was about trying to address health inequalities. Have you been able to evidence from the patient end whether it has improved the management of chronic conditions and whether people who have registered have been in the more at-risk groups, namely people who have been less likely to attend and have their medication managed proactively in the past?

[76] The second aspect is about how your working relationships have progressed with GPs. In the evidence that you have provided, Community Pharmacy Scotland says that the chronic medication service should

[77] 'encourage joint working between GPs and community pharmacists'.

[78] Yet the evidence from the Royal Pharmaceutical Society says that it has not been marketed well to GPs and that some GPs remain relatively disengaged. We know from the evidence that we have had that the barriers between the professions have been a real issue. Despite the joint statements from the two royal societies, there is a clear barrier between some GPs and some pharmacists. So, I am interested in how you have managed to get over that or to what extent you have not, in particular with reference to the chronic medication scheme.

[79] **Mr Clubb:** We are at an early stage with the CMS. We now have 80,000 patients registered for that, and that is the start of our journey with that service. We are doing three key pieces of work over the next three months looking at particular things. First, we are looking at the standardisation of treatments for patients who take methotrexates and for patients who take lithium, and we are looking at introducing a tool to support patients who are just starting on new medicines. The idea is to improve patient safety and ensure appropriate monitoring for lithium and methotrexate to avoid inappropriate hospital admissions. There will also be electronic support in our new care records system, which will be delivered around January. The new medicines service starts around March. The idea behind that is to support patients who have just commenced taking medicines. Historically, lots of patients who start medicines are unsure about asking the pharmacist questions about them. So we want the next generation of medicine-takers, who will be taking medicines for the next 30 to 40 years, to get used to the fact that pharmacists are involved in their care, and ask them questions about it, and then we can encourage them to come back and report side effects. That is a key role for the chronic medication service.

10.15 a.m.

[80] I do not think that we have any evidence about whether we are tackling particular inequalities as yet. The service is available to anyone with a long-term condition. If you came back in a year's time we might have more idea about which particular age groups are registering. Quite often pharmacists are tackling the patients whom they know well—they know patients who come and see them for compliance on a weekly basis much better than the patients they see once every two months, who might pick up an asthma inhaler. In the first instance, they have probably been picking up people on multiple medications who are more likely to be at risk because they do not take them properly, because they are already being monitored for compliance, which suggests that they have an adherence issue. We are getting involved in that.

[81] On the ground, local GP and pharmacist relationships are really important, and some GPs have absolutely brilliant relationships with the local pharmacist. You cannot get around that. I worked in a community pharmacy and I had a brilliant relationship with the general practice, and really enjoyed working with it. We got on well and sorted out lots of problems between us. We reported issues about patients, especially around palliative care, where we shared information about what was happening and what the next steps were—for example, talking about what we had to plan for the weekend to make sure that the patient was okay over the weekend.

[82] The chronic medication service will try to foster some of these relationships, but not everybody gets on with everybody. It may take some time for people to get a really good relationship with their local general practice, because they have never had to before. However, I think that you will be surprised how, in time, some of these barriers melt away. We all have lots of work to do, and we all have individual strengths around the different patient pathways. We feel that we have some expertise in medicines, and GPs have brilliant diagnostic skills, and management skills with patients, and everyone just needs to recognise that we can all help patients in different ways. Patients also need more time to talk about their medicines, to get a better understanding of why they have been prescribed the medicines, what they are taking them for, and what to look out for. That is a key role that a pharmacist has a lot of time for. Unfortunately, not everyone has as much time to give to that, and it is key. We could probably come back in a year's time and give you much more evidence around where we have had key wins in that regard. However, we really have to crack the relationship between GPs and pharmacists.

[83] **Mr MacKinnon:** The professional body makes the point not from a negative point of view, but from a positive point of view, recognising that there is more engagement to do, more talking to do with GPs, more work to do from the Government, and more negotiating for the professional body. We all have a role here in ensuring that GPs understand what this pharmacy service is about, and that it is not about duplication, but about pharmacists' role in pharmaceutical care and medicine safety and ensuring that patients get the full benefit of their medicine. It was a positive comment, but there needs to be more engagement, and we are all committed to that.

[84] **Ms Weir:** I will do the slightly negative bit and say that CMS, as set up originally, has three components—registration, care planning, and serial prescription, which would cover a period of treatment of six to 12 months. The serial prescription element is only operating in a limited number of pharmacies at the moment, where we are testing out the systems and finding out what needs to be tweaked. The reason why we are testing it out is because it involves changes to both doctor and pharmacy systems, and, when you have more than one IT component involved, it seems to more than double the work. We have had some problems there because the doctors were changing the IT system that they used, and that has caused delays.

[85] Going back to the original point about patients, we have been looking at some of the

issues that have come up. To give a simple example, we had a patient reported who was getting a sublingual spray to treat angina, but when he sprayed it, it caused inflammation and a burning sensation, so he stopped taking it, which clearly was not particularly good for that patient. However, he talked to the pharmacist, who was able to substitute it with another product, in discussion with the GP. That patient is now seeing much more benefit from the medicine.

[86] **Vaughan Gething:** You talked about some of the issues between GPs and pharmacists melting away or progressing. Is that based on local relationships and is it just about GPs and pharmacists recognising the need to work together, or is it about a lead given by the health board or from the Scottish Government? I recognise that there are good working relationships in some areas, but not in others. I am interested in knowing how progress is being mapped—or is it something that you just expect to happen over time?

[87] **Ms Weir:** We had discussions with officials about the contracts and it was made clear to us in several meetings that we should be looking, when we are working on the development of the contracts, at how the contracts fit together. There is an issue there in that pharmacy has a Scottish contract, as does optometry—we believe that the dentists have one as well—but the GPs' contract is UK-wide. So, you need to think about whether that is the best way of having the systems merge. That is something to look at for the future.

[88] In terms of meetings, we have a meeting set up with the BMA next month, when we will be looking at a number of issues—perhaps CMS and some of the issues to do with the shortage of medicines. So, we do try to have dialogue with it as well.

[89] **Kirsty Williams:** Page 8 of your evidence talks about the Scottish contract. Under the list of weaknesses in the contract, you talk about the effect that the implementation of category M changes on an England-and-Wales basis had on Scotland. Could you expand on that paragraph, please, and tell us what the implications of that are and how you are addressing them?

[90] **Ms Weir:** Category M is the system that sets the reimbursement prices for generic products. It is a system that was developed by the Department of Health and it is used to modulate the amount of profit made by pharmacists on the drugs that they buy and dispense. The system in England aims to restrict the amount of profit to £500 million. When we entered into the new contract, we adopted the category M prices. When it was decided to change the prices in England to modulate the level of profit, that automatically had an effect in Scotland. We had to see whether we were mimicking the effect or were experiencing more of an effect: if the levels of generic prescribing were different in Scotland, or different in certain areas, that could affect the overall changes that category M prices brought about. It caused difficulties when there was a change in England, and we then had to find out what had happened in Scotland and adjust our whole remuneration system to ensure that the amount of money that we had agreed would be paid to pharmacy contractors was delivered to them.

[91] This last year, in order to give ourselves more stability, we have divorced ourselves from the category M system and have set our own tariff.

[92] **Mark Drakeford:** I have two questions, if there is time. One of them may be dealt with relatively quickly. On the business of registration, I can see easily enough how, if you are in a community where there is a single GP practice and a single pharmacy, registration would be straightforward. Can you tell us anything about your experience in urban parts of Scotland, where patients have a choice of pharmacies? How does registration work there, from the patient's point of view?

[93] **Mr Clubb:** My own experience is that I was dragged up in a small town called

Musselburgh, which has four pharmacies. Despite the fact that it has four pharmacies and three GP practices, patients are still relatively loyal to their pharmacy. They have one pharmacy that they will traditionally use. When you go into the GP system, each pharmacy will be flagged for a patient—the choice will almost already have been made, because most of the pharmacies operate collection services from surgeries on behalf of patients. So, most patients with long-term conditions are already loyal to a particular pharmacy. Despite the fact that there may be a wide range of choice, we find that most patients have already chosen which pharmacy they will use. Even in an urban area, it does not make much of a difference. People have already a chosen pharmacy, which they already have a relationship with and, therefore, it makes no difference.

[94] **Mark Drakeford:** Thank you, that is very helpful. My second question might be a little more difficult. In looking at the four core pharmacy services in the Scottish contract, if we as a committee were to make any recommendations to our Minister about moving ahead in any of these areas, I doubt that we would be in a position to tell her that she should do all four in one go. So, if you were to recommend to us how we might prioritise between those four and if we were to have to tell the Minister to start somewhere, are there any two of them that you think would be a better starting place than the others?

[95] **Mr Clubb:** May I ask a question of you? What do you think are the greatest priorities in health in Wales today?

[96] **Mark Drakeford:** In the three minutes that we have left, we would struggle to answer that question. [*Laughter.*] However, access is a theme that has arisen frequently during this inquiry, as is chronic conditions management.

[97] **Mr Clubb:** I would say that you have answered your own question, then: you need a minor ailments service and a chronic medication service.

[98] **Mark Drakeford:** I am interested to hear about your experience and whether, of the four of them, you think any one or two have more value than the others on the ground, as a starting point. If you cannot answer, then that is fine, but if you could, it would be helpful as part of the general landscape that we are exploring.

[99] **Mr Clubb:** The older population is expanding and older people will become more unwell as time goes on. They will still be alive, but they will be on more complex medication regimens, and will have difficulties around poorer renal and liver functions. So, the chronic medication service is the big one, whatever happens. More support for chronic medication would be the big one, as far as I am concerned. Trying to reduce the number of hospital admissions through improved use of medicines and so on will probably drive the biggest amount of savings. However, culturally, to try to move pharmacists into different areas, the minor ailments service is a good place to go and it gives patients confidence in understanding what their pharmacist is able to do for them.

[100] **Mr MacKinnon:** I would agree with that 100 per cent. I would recommend a chronic medication service. It is about making the best use of pharmacists' skills, improving the pharmaceutical care of patients and medicine safety and improving concordance, compliance, and so on. That is where a pharmacist can really make a difference. I agree that a minor ailments service is an excellent way of opening up access for common clinical conditions. It is also good service to start with as a platform on which to build the others. That is my view.

[101] **Ms Weir:** It is important that we move away from the idea that you go in and get a prescription and then get out as quickly as possible. We need to use a minor ailments service to help to position community pharmacy within the NHS as a whole. That starts to develop the relationships, which will be more important in later years.

[102] **Mark Drakeford:** Thank you very much indeed, not only for that last answer but for all of the evidence that you have provided to us this morning. It has been very helpful indeed for us to be able to explore these issues with you. We have just a minute or two left. Inevitably in these discussions, there are sometimes points that do not emerge as strongly as you might think that they ought to. So, if there are any things that you think that we have not managed to cover, or any last points that you would like to ensure we take away, it would be very helpful for us if you could identify them. If not, and if we have managed to do it all, then that is good news, too.

[103] **Ms Weir:** The only thing is that if you are going to be working on the development of a contract, we started with the principles and considered what we were trying to do, who we were trying to deliver it for, and how we would do it. So, we set out to get these principles to start with and then the work was done to underpin the delivery of those principles.

[104] **Mr MacKinnon:** The work that both organisations that are here today representing Scotland have done to make politicians aware over the last decade and a half of the skills and the potential for community pharmacists to help deliver services in the process of modernising the NHS has been vital. It was that full cross-party support and commitment from politicians over the last decade that enabled this to happen. It has got us to where we are today. It was a 10-year process from the establishment from devolution. However, it was about that cross-party commitment and recognition, not just by Government—politicians wanted to make better use of pharmacists' skills in the modern NHS in Scotland.

10.30 a.m.

[105] **Mr Clubb:** You should also look at your funding stream and make sure that your funding is stable during any period of change. That is a key thing. It is pretty much managed in Scotland. You should also make sure that premises have suitable facilities available for patients, to give them more confidence in any services that are provided.

[106] **Mark Drakeford:** Excellent. Thank you all; we are very grateful to you. At that point, we will bring this item to a close. I also thank members of the committee—it is not as easy when people are distant from you, but I hope that you thought that it was useful; I certainly did.

10.31 a.m.

**Deiseb ar Ddarpariaeth Toiledau Cyhoeddus yng Nghymru—Ystyried Dull y
Pwyllgor Iechyd a Gofal Cyndeithasol o Weithredu
Petition on Public Toilet Provision in Wales—Consideration of the
Health and Social Care Committee's Approach**

[107] **Mark Drakeford:** Mae papur 3 ar yr agenda yn awgrymu ffordd ymlaen i ni. **Mark Drakeford:** Paper 3 on the agenda suggests a way forward for us.

[108] You will see that there is a set of suggestions in paper 3 supporting this item, giving us a suggested timetable for the brief inquiry that we will hold into this matter. There are some suggested witnesses and a list of potential consultees. My main anxiety is that we are as clear as we can be with people who will be interested in our work in this area that our remit is one of public health. We are not the committee that has the responsibility for the provision of public toilets—I do not want to give people a false expectation about what we might be able to achieve for them in this area. However, there is an important piece of work that we can do, and we want to make the most of it.

[109] **William Graham:** On what you just said, Chair, we are hearing from all the complainants but we are not hearing from any of the facilitators. Is that intentional?

[110] **Mark Drakeford:** Not necessarily.

[111] **William Graham:** I would have thought the Welsh Local Government Association or One Voice Wales could be consulted, to at least get the other side of the story.

[112] **Mark Drakeford:** I agree. Did you mention another group apart from the WLGA?

[113] **William Graham:** I mentioned One Voice Wales or possibly community councils, or organisations like that that deal with these issues.

[114] **Mark Drakeford:** Obviously, local government has direct public health responsibilities of its own, so we can legitimately ask its representatives to come.

[115] **Lindsay Whittle:** Are there any private-company-sponsored loos? Are there any companies that provide them and happily take the money, as long as you give them a site?

[116] **Mark Drakeford:** We will find out; I do not know, but it is a good point.

[117] **Elin Jones:** That is only for the portable ones.

[118] **Lindsay Whittle:** I am always afraid to go in to those, in case I never come back out, and am found bobbing up and down in one in the Bristol channel. [*Laughter.*]

[119] **Kirsty Williams:** I do not know about private companies, but there are examples of community groups that have taken on the running and maintenance of public toilets in the face of councils not wanting to do that anymore. I do not know whether they would be represented in one of these all-encompassing groups, but it might be useful to hear from communities that have said ‘You don’t want to do it, but we will’, about how they have managed to overcome some of the barriers around insurance and compliance with the Disability Discrimination Act 1995, and how they manage that within their community. I can think of at least one such group in my constituency.

[120] **Mark Drakeford:** That would be very interesting.

[121] **William Graham:** Would One Voice Wales cover that?

[122] **Kirsty Williams:** They are outside of the council—they are just a group of volunteers. They are nothing to do with the community council—they are just a group of concerned local residents.

[123] **Mark Drakeford:** It would be very interesting to hear from them.

[124] **Mick Antoniw:** There are two main providers, are there not? We have local authorities and local businesses—shops, stores and so on. Those are the parameters. I do not know how one would engage beyond the local authorities. It might be complex to go down that road.

[125] **Vaughan Gething:** Is there a forum for retailers, be they individual retailers or groups of retailers in retail parks?

[126] **William Graham:** Perhaps the British Retail Consortium could give evidence.

[127] **Mark Drakeford:** We should certainly add it to the list of potential consultees.

[128] **William Graham:** In a way, it provides a public service to large numbers of people.

[129] **Mark Drakeford:** There is also a Welsh Government scheme—I think that Elin will remember it better than me—where the Government gives money to organisations in this regard. I believe that Dr Brian Gibbons was responsible for launching that scheme. As part of its wider evidence, we ought to be able to get a report from the Government as to what the strengths and weaknesses of the scheme have turned out to be.

[130] **Rebecca Evans:** I wonder whether the length of the consultation period is sufficient, given that we are potentially going to try to contact community groups as well. At present, the consultation will close just before Christmas. Is the length of the consultation period going to be a consideration?

[131] **Ms Dafydd:** The only implications are that we either have a shorter period of time in which to take evidence into consideration before the session or that we delay the session a little. At the moment, we are looking at 19 January as a date for the oral evidence session. However, we could look for a later date if you would prefer to extend the consultation period. The reason that we are closing the consultation before Christmas is that the period after Christmas is often not very productive in terms of the information that we receive. We need to close it before Christmas to have time to deliver for the oral evidence session on 19 January. It is entirely up to the committee as to whether it would like to delay that session.

[132] **Rebecca Evans:** I suppose that a lot of the organisations already expect to be contacted.

[133] **Mark Drakeford:** We have already publicised the fact that we are going to undertake this inquiry. Given that it is a fairly live issue—people are interested in it and are talking to each other about it—shall we take the risk and give them the four weeks to reply? It was a good point, though.

[134] Other than that, are Members content with the additions to the list of consultees? I see that you are.

10.38 a.m.

Papurau i'w Nodi Papers to Note

Mark Drakeford: Dim ond dau bapur sydd i'w nodi. Yr ydym wedi cael cofnodion y cyfarfod ar 10 Tachwedd, ac nid oes unrhyw sylwadau wedi'u cyflwyno arnynt. Yn ail, mae angen nodi'r dystiolaeth ychwanegol a gyflwynwyd gan Fferylliaeth Gymunedol Cymru yn y maes yr ydym wedi bod yn ei drafod y bore yma, sef y profiadau yn yr Alban.

Mark Drakeford: We have only two papers to note. We have received the minutes of the meeting held on 10 November, and no comments have come forward in relation to those. Secondly, we need to note the additional evidence that has been submitted by Community Pharmacy Wales on the matter that we have been discussing this morning, namely the experiences in Scotland.

10.39 a.m.

**Cynnig o dan Reol Sefydlog Rhif 17.42(vi) i Benderfynu Gwahardd y
Cyhoedd o'r Cyfarfod ar Gyfer Eitem 6
Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public
from the Meeting for Item 6**

[135] **Mark Drakeford:** Cynigiaf fod

Mark Drakeford: I move that

y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog Rhif 17.42(vi).

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).

[136] Gwelaf fod y pwyllgor yn gytûn.

I see that the committee is in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 10.39 a.m.
The public part of the meeting ended at 10.39 a.m.*