



Cynulliad Cenedlaethol Cymru The National Assembly for Wales

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

**Dydd Mercher, 11 Ionawr 2012
Wednesday, 11 January 2012**

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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynnddi 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
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**

Andrew Evans	Uwch-gynghorydd Polisi (Fferylliaeth) Senior Policy Advisor (Pharmacy)
Lesley Griffiths	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Dr Gwyn Thomas	Prif Swyddog Gwybodaeth Chief Information Officer
Yr Athro / Professor Roger Walker	Prif Swyddog Fferyllol Chief Pharmaceutical Officer

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 9.46 a.m.
The meeting began at 9.46 a.m.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

- [1] **Mark Drakeford:** Bore da. Croeso yn ôl ar ôl y Nadolig i bawb, a chroeso yn arbennig yn ôl i'r pwyllgor i Darren. Fel mae pawb yn gwybod, yr ydym yn hollol ddwyieithog, ac mae hon yn sesiwn gyhoeddus, felly mae'r meicroffonau i gyd yn gweithio yn awtomatig. Nid oes gennym unrhyw ymddiheuriadau'r bore yma.
- Mark Drakeford:** Good morning. Welcome back after Christmas to everyone, and a special welcome back to the committee to Darren. As everyone knows, we are entirely bilingual, and this is a public session, so the microphones will all operate automatically. We have received no apologies this morning.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Trafod Amserlen yr Ymchwiliad a Phenodi Cynghorydd Arbenigol Inquiry into Residential Care for Older People—Discussion on the Inquiry Timetable and Appointment of Expert Adviser

- [2] **Mark Drakeford:** We are being asked to resolve a number of practical things this morning under item 2. The first is to check paper 1a, which you all have, with everyone. It lists a set of proposed oral sessions in the way that we asked our clerks to do before Christmas. You will remember that we asked them to try to ensure that we heard from witnesses in a relatively coherent way by grouping them together to represent a particular voice or perspective, rather than taking people when they were able to turn up. In the annex in paper 1a, there are eight sessions that try to group witnesses together in that way. So, the first question for this morning is whether Members are happy with that, whether you think that there is anything missing from the list and whether more time needs to be allocated to any of these sessions than others, and so on.
- [3] **Vaughan Gething:** One of the things that we discussed was the balance of provision and new and emerging models. That is quite an important aspect. In relation to session 5, nothing is stated about the not-for-profit sector specifically, and I would like to see something about that in there. That needs to be a larger session in order to look at those alternative models, rather than standard models of care, as well as the new and emerging models that may come from the social enterprise and not-for-profit sectors.
- [4] **Mark Drakeford:** So, that is in session 5 with the third sector.
- [5] **Vaughan Gething:** It may mean additional names and having that on one of the longer days so that more evidence is provided.
- [6] **Mark Drakeford:** Lindsay, I think that before Christmas you gave us the name of an organisation that already provides not-for-profit residential care services.
- [7] **Lindsay Whittle:** Yes. I was wondering into which category registered social landlords, who are not-for-profit, would fall. You would not call them private sector providers, and I do not see them listed in the public sector. They fall in between, do they not?
- [8] **Mark Drakeford:** So, could we add them to an expanded session 5, in which we would ensure that we heard from registered social landlords in Wales?
- [9] **Lindsay Whittle:** It is a pretty large sector, but I think that it should be there.
- [10] **Mark Drakeford:** Is there anyone else? Mick—*[Interruption.]* It was Christmas spirit.

- [11] **Lindsay Whittle:** Post-Christmas spirit.
- [12] **Mick Antoniw:** This Friday is the Ukrainian new year.
- [13] Unison is listed as one of the professional and staff bodies in session 6, which is fine, although I think that it is more social service-oriented. One of the main staff unions is GMB, which was very heavily involved in research and analysis over the Southern Cross stuff. A lot of that background corporate information might be quite useful, so an approach to it, whether regionally or nationally, would be appropriate.
- [14] **William Graham:** My question is on session 4, with private sector providers. Are we confident that the organisations listed will represent all the private sector providers? They are the majority providers in Wales. We should engage with them.
- [15] **Mark Drakeford:** We inevitably, in a way, end up hearing from umbrella organisations and representative organisations. Does anyone know of any names that are not on this list?
- [16] **Mick Antoniw:** Are we not going to ask Four Seasons Health Care, for example? It seems to have stepped in a lot for Southern Cross. It is one of the big corporate providers. It has recently taken over from the collapsed Southern Cross, so what it has to say is quite important.
- [17] **Mark Drakeford:** It is certainly the case that Four Seasons has taken on the majority of Southern Cross homes in south Wales, so we could hear from it.
- [18] **William Graham:** We will be inviting written representation from everyone, anyway, but these are umbrella organisations, are they not?
- [19] **Mark Drakeford:** If anyone thinks of any other organisations that we ought to hear from in that fourth session, that would be useful in order to add to the list.
- [20] **Darren Millar:** In session 7, could we invite the Royal College of Nursing? I know that it has expressed some strong views on the need to regulate in relation to healthcare support workers in the past and I am sure that it would want to contribute to that discussion.
- [21] **Vaughan Gething:** Would that be in session 7 or 6?
- [22] **Lindsay Whittle:** Session 6, probably.
- [23] **Darren Millar:** Yes, but it is particularly interested in the regulation of healthcare support workers.
- [24] **Vaughan Gething:** But it is a staff body.
- [25] **Darren Millar:** Okay, but session 7 is on regulation. So, either we overlap those two sessions in some way and have an extended day, so there is a bit of crossover, or—
- [26] **Lynne Neagle:** I am sure that the staff bodies generally will have a view on regulation, so there is bound to be an overlap, is there not?
- [27] **Mark Drakeford:** Let us explore with it where it thinks that it would like to give evidence. Darren is quite right; some of us will know that it was hoping to promote a private Member's Bill at one stage which was very much to do with regulation of the professions in

the residential care field. Let us see where it thinks that its evidence would best fit. Thank you for that.

[28] **Elin Jones:** On regulation and inspection, there are such people as lay assessors who are appointed to the inspection teams that go around, and we will possibly not hear their voice through the inspectorate coming to talk to us. I am not sure how we would get their voice, but they might be able to add something different based on their knowledge. I do not know how you would access that, but trying to see whether we could get something on that would be useful.

[29] **Mark Drakeford:** We will ask Llinos to have a look at that. We can make it clear to the inspectorate that we want to ensure that some lay inspectors come. The trouble with that is that it would select them for us, which is maybe not quite what we want. However, there will be ways of doing that and we will find them. Other than that, are we happy that this is a decent schedule of witnesses, which will allow us to take evidence in a coherent way? I see that we are.

[30] The second thing that we need to think a bit about today—again, we discussed this before Christmas—in terms of annex B and the six specific strands in our terms of reference, is whether Members might be willing to identify one or two in which they will take a particular interest during the inquiry. We will all take an interest in all of them, but, if Members say that they will keep a particular watch over one or two, we will have timetabled sessions, as we agreed, for Members to take the inquiry outside Cardiff, meet organisations and talk to individuals. That might be a way of helping to structure that. Members would be exploring their particular theme when they did that work on behalf of the committee. I do not know whether anyone has had a chance to think about which of these they would be prepared to sign up to. If Members have, we can take expressions of interest from around the table now or at the end of the meeting, when you will have had a chance to think about it, and, where Members have not had a chance to do that, we can also write during the week. If anyone wants to make a bid, we can take it now.

[31] **Mick Antoniw:** I am quite interested in the public/independent sector balance issue.

[32] **Mark Drakeford:** Okay. That is the final one on the list.

[33] **Rebecca Evans:** I would be interested in taking forward the work on the capacity of the residential care sector to meet demand for services in terms of skills mix and training. That is the second one.

[34] **Vaughan Gething:** I am especially interested in the new and emerging models of care provision.

[35] **Darren Millar:** Regulation for me.

[36] **Lindsay Whittle:** I am happy to look at the quality of residential care and the experiences of service users, and at the management of care home closures, having undergone that traumatic experience, in a previous life, as the leader of Caerphilly County Borough Council.

[37] **William Graham:** There are fewer options than Members.

[38] **Mark Drakeford:** I hope that there will be two Members doing almost all of them.

[39] **William Graham:** Excellent. In that case, I would prefer the quality of residential care services.

[40] **Mark Drakeford:** Kirsty, do you have any thoughts?

[41] **Kirsty Williams:** I am interested in quality issues and in new and emerging models of care, because there is a huge diversity now in what is available and in people's expectations. Some authorities' care provision is what it was 20 or 30 years ago, while some authorities are providing fantastic new opportunities for people. So, new and emerging models for me.

[42] **Mark Drakeford:** In saying that, you have reminded me, in relation to the first list that we looked at, that some of you will have seen that some visitors from Quebec, who are directly involved in organising care, will be in Wales at the beginning of February—half the residential care for older people in Quebec is apparently provided by the co-operative sector. They will be coming to the Assembly for half a day, at least. I think that Rosemary is hosting a meeting with them. So, I hope that we might manage to hear from them, because, in terms of new and emerging models, that is a model that is happening and on a big scale.

[43] Elin, do you have any thoughts for today?

[44] **Elin Jones:** No-one has mentioned the first one, and I am quite interested in access issues.

[45] **Lynne Neagle:** For me, it would be quality issues and also I have had some fairly painful experience of a care home closure.

[46] **Mark Drakeford:** Excellent. That is really helpful. Thank you very much for that. We will put all those things together and see where there might be any gaps. As I said, when we go out on visits and so on, it might often be helpful if two of us managed to go together rather than us doing it single-handedly, but we will see how that works out.

[47] **Mick Antoniw:** Chair, it seems to me that there is overlap in these areas—certainly new and emerging models and balance overlap. One automatically leads into the other. We should be flexible in the way in which we operate, so that we do not create artificial barriers.

[48] **Mark Drakeford:** So, the third practical thing with regard to this item that we need to think about this morning is the appointment of an expert adviser for the inquiry. You will see the specification that was drawn up, against which potential candidates were sought. By today's meeting, we have two people who are potential advisers against that specification. I want Members to have a think about two things. First, are we sure that this is the advice that we need? Are we getting the expertise in the areas in which we most need expertise to be added to what we will hear from witnesses and other sources? If we are sure that that is right, do we think that either of the candidates ought to be approached more formally, or do we want to continue thinking about it and look for more names? I do not think that we have to rush to conclude this business today, if people are not confident that we have what we need. However, if we are confident and we want to do it, that is fine, too. I do not want anybody to feel that they are being rushed along.

10.00 a.m.

[49] **Lindsay Whittle:** How have we arrived at these names? It seems strange that they are both from Bangor University.

[50] **Mark Drakeford:** Or 'North Wales Coast', as it might now be known.

[51] **Kirsty Williams:** There is nothing intrinsically strange about the fact that they are

both from Bangor University.

[52] **Lindsay Whittle:** No—I would like to be a fly on the wall in the staff room there, that is all.

[53] **Ms Dafydd:** The Assembly holds a research database that contains the names of those who have put themselves forward for expert advice work. Names were sought on that database. In addition, we looked to see where there were academics, in Wales and beyond, doing work that has relevance in this area and who would lend themselves to being put forward as an expert adviser. We spoke to five individuals—you will see in paragraph 8 of the paper the names of those to whom we spoke. Unfortunately, three of the five were unable to commit the time necessary for this work at this point in the year, which left us with the two named, both of whom happen to be at Bangor. There was no reason for that, specifically, when we were looking for expert advice. Steve, as the research leader, and I have both spoken to the individuals to explain the type of work the specification would require of them, and we have made it clear that it would be for the committee to decide whether this specification meets your needs for this inquiry and that, if it does not and is amended, we may need to look again at the candidates for this role. So, it is for the committee to decide on the specification and then the candidate.

[54] **Lindsay Whittle:** Thank you.

[55] **Mick Antoniwi:** My first reflection is that, looking at the role specification and the time allocated, and bearing in mind that we will no doubt be seeking someone with a degree of expertise, who will most certainly be busy, I wonder how realistic the time assessments are, bearing in mind what we know about the amount of work and how technical some of it can be. That is my first comment, because someone who is looking at this will try to work out whether they would be able to fit this type of work in with their existing role, as it is not a full-time position. I would like some comments on that.

[56] My other point is that we are clearly going to get into issues of finance, quite complex corporate issues and the practical issues with regard to how this whole area has developed and is run. The two candidates seem very highly qualified, but do they have the required level of practical, hands-on expertise? My inclination is that we should probably not jump into this. I am not really sure that these two candidates will actually add a great deal more than what is already available to us. Perhaps we should be casting the net wider and thinking more deeply about the type of person we want.

[57] **Mark Drakeford:** In terms of the days and the work, there is an issue to do with procurement, which is that once you go above 15 days, we would have to go out to procure someone to help us, and, by the time we got somebody, Kirsty will probably have started interviewing some of us as part of her interest in people applying for residential care admission. [*Laughter.*] So, if we can keep it below that threshold, at least we will be able to get an adviser within the timescale. Are there any other views on whether we ought to think about this a bit more and cast the net wider, as Mick said.

[58] **Darren Millar:** In terms of the 15 days, I would favour trying to get an adviser from outside Wales with a wider perspective on these issues. I think an academic would be suitable, as someone who has not had direct experience in any particular part of the industry, because you would get their particular industry view through the lens of their experience rather than an overview of the range of views that is there. If possible, we should try to get someone from outside of Wales, although Dr Sedden was a strong candidate.

[59] **Elin Jones:** I do not disagree with casting the net wider than Wales, but I would not want this committee to agree to a principle that we should get our advisers from outside

Wales. I am finding it quite difficult to judge between these two individuals. I am not too sure what I am being asked to do, because they are both quite similar in terms of what they have noted regarding their roles. So, I am more than happy to delegate this particular issue to the Chair and others, who could look into it in a bit more detail than I am able to do here with just this choice in front of me.

[60] **Kirsty Williams:** I agree with Elin. It is not possible to appoint special advisers by committee in this forum. The Chair's role is not just to chair the meetings, but to take overall leadership of the committee's work, and I am happy to delegate it to the Chair.

[61] **Mark Drakeford:** I will test one thing with you to see what you think. My reading was that neither provided expertise in the way the residential care industry operates. Most residential care services in Wales are commercial organisations, commercially driven and organised, and that is part of the reason we are looking at them. So, to be able to understand the way in which the industry operates, as profit-orientated commercial organisations, and not as a social service, we need someone who can give us an insight into that side of it. These two candidates have a strength in the social service aspect. I do not see people among our witnesses either who have a strength in that field. So, if we are going to look a bit more widely, we might see that there is someone who could help us a bit more with analysing and understanding that side of the work. I see that you agree. In that case, we will look a bit more widely to see if there are other sources of expertise. I will then report back to you on what we are able to do. That is all we have to do today on that part of the agenda.

10.08 a.m.

**Y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru)—Trafod y Dull o
Ystyried y Bil Drafft
Draft Food Hygiene Rating (Wales) Bill—Discussion on approach to
consideration of Draft Bill**

[62] **Mark Drakeford:** Since we last met, the Minister for Health and Social Services has published a draft Bill in relation to food hygiene rating. As a small piece of background, those of you who have had a chance to look at the Bill will have seen that although it is promoted by the Minister for Health and Social Services and has a public health component, the detail of the Bill is all about a local government scheme in the field of commercial business. So, there are at least three committees that could, theoretically, be identified by the Business Committee as taking the lead responsibility for the Bill. It could well be us, or it could be the local government or enterprise committees.

[63] We had a discussion of principle before Christmas when we looked at the White Paper on organ donation. We concluded then that we did not want to enter into the White Paper consultation as though we were a consultee, and potentially confuse people about what our real role will be when the first stage of the actual Bill has to be discussed. My inclination is to suggest to you that we should adopt the same principle here: this is a draft Bill, and it is out to consultation. In the organ donation context, we have agreed to have an early session with officials so that we understand what the Government is intending to achieve, how the organ donation White Paper has been constructed, what the key questions are, how it is going about consultation, and so on.

[64] We will have a further meeting with those officials when the consultation is concluded to keep ourselves in touch with the way that picture is emerging. I am inclined to suggest to you that we do the same with this draft Bill. We should have a session with officials to ensure that, were this Bill to come to us, we would be properly up to speed with the thinking behind it, what it is intended to achieve and so on. We would meet them again

when they have had a chance to conclude their consultation and think of the responses. Even if it does not come to us in the end, we will still be able to feed in observations to this from a public health perspective, so it will not be wasted work. If it does come to us, we will be a committee that is informed and up to speed on the detailed scrutiny we will then be asked to undertake. That is my suggestion, but does anyone have any other thoughts?

[65] **Kirsty Williams:** I think that that is the most sensible way forward. I do not think that the Assembly should get into the habit of commenting on draft Bills. There is a role for draft legislation, which is to consult widely, but our role is to look at the actual legislation brought forward by the Government after the consultation. So I am quite happy to proceed in the way you have suggested, Mark.

[66] **Mark Drakeford:** Thank you very much.

[67] **William Graham:** I support what you suggest, Chair. I found the session with officials for the organ donation legislation extremely valuable.

[68] **Mark Drakeford:** Yes, it was good. Excellent. We will ask the clerk to find some time to feed those two sessions into our timetable. We will be able to take a short break before the Minister arrives at 10.30 a.m., but as we may be pressed for time towards the end of the meeting perhaps we can deal with item 5 now.

10.12 a.m.

Papurau i'w Nodi Papers to Note

[69] **Mark Drakeford:** Members can see what we have there. I reported to you before Christmas—but you can see it in the papers now—that we had had a letter from Gwenda Thomas as the Deputy Minister saying that she has decided to hold back on setting up her own task and finish group on residential care services pending this committee's work in that field. She has also written to us following the scrutiny session we had with her and Lesley Griffiths on the budget when she promised to provide us with more detailed information on the First Steps improvement package in relation to domiciliary care services. You will see that there is quite a detailed letter from Gwenda. We have also received some additional evidence from previous witnesses to the community pharmacy inquiry, which is also at the end of your papers for today.

[70] **Rebecca Evans:** I have a question on the minutes. I asked for a list of the third sector organisations that have been actively engaged in the consultation process so far on organ donation. Have you received that from the Minister? I am sure that I did not see it among the papers.

[71] **Ms Dafydd:** It was circulated to Members by e-mail before Christmas, but it is not here as a paper to note. We will ensure that it is on the agenda next week. We also received some more information yesterday, which was circulated to Members, providing dates for the public meetings that will take place in January. We will put it all together and put it on the agenda next week for you to note.

[72] **Rebecca Evans:** Great, thank you.

[73] **Mark Drakeford:** While we have a few minutes to spare, I wish to remind people of a couple of housekeeping issues. To confirm for Members, on the afternoon of Tuesday 2 February, we will have the second of our more informal events. We had one on patient voice before Christmas. At this one, we will be looking at the process by which access to medicines

in Wales is organised. Professor Phil Routledge, who is a former chair of the All-Wales Medicines Strategy Group and wrote a report on that process for the previous Minister for Health and Social Services, is going to come to talk to us about it. We will also have a senior clinician in the cancer field to talk to us about how the process works from his perspective and a former chief executive of a health trust, as it would have been then in Wales, to tell us how the system works from a senior administrator's perspective. We will also have somebody who can talk about the patient experience.

10.15 a.m.

[74] All of us, as individual Members, deal with constituency cases where people have run into this system. We will also have somebody from the pharmaceutical industry, which tends to promote the newer drugs, to talk about its perspective. It will be a chance for Members to do two things, the first of which is to ensure that we understand the landscape, how different parts of the jigsaw fit together and how individual patient exceptions can happen, or do not happen, and so on. It is partly to ensure that we better understand the system. Secondly, we will be able to explore how the key players within the system think that it gets applied in practice. At the end of that, as we did with the previous one, we can either decide that we have heard all we need to hear and have taken it as far as we want to, or we could decide that the committee would like to do a bigger piece of work, having heard from the people who helped us on it. That is planned for the afternoon of Thursday 2 February.

[75] Some committees have signed up to a scrutiny master-class from John Sturrock QC, who has been helping Members with scrutiny in general, in terms of how to go about it and make the most of the time that we have. That is different to what we had previously on the legislative side of things. Some Members may have already come across John Sturrock through other committees that they have sat on. The opportunity is there for us to have a session with him, a bit like the session that we had with Mr Greenberg before Christmas. We do not have to think about it now, but the offer is there for us to consider. We will come back to it to hear if it is an opportunity that you would like to organise.

*Gohiriwyd y cyfarfod rhwng 10.17 a.m. a 10.29 a.m.
The meeting adjourned between 10.17 a.m. and 10.29 a.m.*

**Ymchwiliad i'r Cyfraniad a wneir gan Fferyllfeydd Cymunedol i
Wasanaethau Iechyd yng Nghymru: Tystiolaeth gan y Gweinidog Iechyd a
Gwasanaethau Cymdeithasol
Inquiry into the Contribution of Community Pharmacy to Health Services in
Wales: Evidence from the Minister for Health and Social Services**

[76] **Mark Drakeford:** Dyma'r sesiwn olaf yn ein hymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru. Croeso arbennig i Lesley Griffiths, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, a hefyd i Dr Gwyn Thomas, prif swyddog gwybodaeth Llywodraeth Cymru, Andrew Evans, uwchgynghorydd polisi Llywodraeth Cymru, a'r Athro Roger Walker, prif swyddog fferyllol Llywodraeth Cymru. Croeso ichi, a diolch yn fawr am ddod y bore yma. Trof yn gyntaf at y Gweinidog.

Mark Drakeford: This is the final session of our inquiry into the contribution of community pharmacy to health services in Wales. A warm welcome to Lesley Griffiths, the Minister for Health and Social Services, and also to Dr Gwyn Thomas, the Welsh Government's chief information officer, Andrew Evans, senior policy adviser for the Welsh Government, and Professor Roger Walker, the Welsh Government's chief pharmaceutical officer. Welcome, and thank you for coming this morning. I will first turn to the Minister.

[77] Lesley, do you want to make any brief opening remarks before we turn to Members' questions?

[78] **The Minister for Health and Social Services (Lesley Griffiths):** Yes, Chair. I am grateful for the opportunity to give evidence to the committee. I have sent you a paper, but I want to highlight some of the achievements and progress that we have made with community pharmacies over the past few years. You will be aware that we have made a substantial investment to support the development of community pharmacy services and, since the new pharmacy contractual framework was introduced in 2005, we have increased the budget to fund services by 51%. The budget stands at £145 million this year, excluding funding for the cost of medicines prescribed. A further £2.3 million has funded the provision of needle exchange services and the supervised administration of substitute medication for opiate addiction. As in every part of the NHS, education and training is important, and we have provided £4.3 million for the pre-registration and post-registration education and training of pharmacists.

[79] We have supported the new community pharmacy contractual framework, which, as I said, was established in 2005. This contract signals a step change in the role of community pharmacies, recognising for the first time the distinctive contribution that they can make across a wide range of health issues. The new contract also recognises for the first time the role that they can play in providing advice and information to individuals to help them care for themselves much more. In April last year, we launched the emergency hormonal contraception service, which is now available in nearly 55% of community pharmacies across Wales. To date, just under 19,500 individuals have accessed that service.

[80] The information technology structure, in which I know the committee is interested, is crucial to supporting the changing role of community pharmacy. Again, on top of the funding that I have already described, we have put in an extra £12.5 million since 2005 to support health informatics within the community pharmacy services. This has provided our community pharmacies with secure access to the NHS network and the ability to submit dispensing claims electronically.

[81] That concludes what I want to say for the moment. We require much more collaboration within all aspects of the health service, and community pharmacy has a huge role to play in that.

[82] **Mark Drakeford:** Thank you for that, Minister, and for the paper that you provided for us. We now turn to questions from Members.

[83] **William Graham:** On the level of information, it is a perennial problem, is it not, for people to know how to access health services? Could you describe how you intend to make the public aware of these enhanced roles for community pharmacies?

[84] **Lesley Griffiths:** You are right that there has been a fragmented giving of information about what was available from community pharmacies. We have developed the all-Wales pharmacy database, which is able to capture information regarding all of the available services. We must now work with stakeholders, such as local health boards, to ensure that they give out that information to the local population, so that they are aware of what the pharmacy can provide and how it can sometimes be a first port of call for minor ailments, for instance. The database that has been designed means that we now have a reliable and consistent list of services that are available to patients. NHS Direct can also access the information.

[85] **William Graham:** We heard in evidence that a large number of pharmacies are not at the high level needed to be able to provide all the services that we would ideally want. How do

you hope to boost those numbers?

[86] **Lesley Griffiths:** It is obviously up to local health boards how they use the local pharmacies. It is something that I am committed to doing, and I meet with the chairs of the LHBs regularly. I do not expect all pharmacies to provide all services; it is up to the LHBs to provide for their local population.

[87] **Vaughan Gething:** There are a number of aspects that are of interest, but I will go back to some of the evidence that we heard from Scotland, which was particularly interesting in two different aspects. One was the way that payments are made to pharmacies in Scotland. Rather than being payment on the basis of medication dispensed, it has what it calls banded capitation, which appears to be something along the lines of the number of patients registered with pharmacies. So, it is a different system, with an element of registration. Some of those who have given evidence thought that that would be a progressive move. Has the Government given any thought to that, particularly as we know that there are going to be changes to the contract in England? Have you thought of a different way to deliver the payment mechanism here?

[88] **Lesley Griffiths:** Registration of patients with pharmacies is something on which I would be very keen. When we implement the minor ailments scheme, I would want to see patients registered with a pharmacy. I will bring Roger in to say a bit more about that.

[89] **Professor Walker:** We have had discussions about this on a number of levels, but what we have to do is address the fact that a vast proportion of pharmacy income comes from dispensing prescriptions—generally, NHS income is 70% to 90% of their income, of which the majority is from prescriptions. What we have to do is provide stable financial development for contractors so that they feel safe and secure to allow us to develop and provide these services. It is crucial that some patients are registered with individual contractors, so that the contractor is aware of the detailed history of that individual and can provide additional support to them in addition to the routine supply of medication.

[90] **Vaughan Gething:** One thing that comes from that, including on sharing information—which others may want to ask about—is that, when we spoke to pharmacists from Scotland and asked them the fairly simple question of whether they would recommend minor ailments or chronic disease management as a focus for community pharmacies as the one additional measure that we should recommend, they were very clear that it should be chronic disease management. I am interested in the priorities that you have set. Would you reconsider your position in terms of how you would use community pharmacies for chronic disease management and the role that you might see for medicine use reviews in that?

[91] **Lesley Griffiths:** The minor ailments scheme is a manifesto commitment, and I am very committed to it. I am doing a great deal of work on it at the moment—we are looking at scoping papers, and I am more or less decided on what I would like to see. I would like all pharmacies to offer a minor ailments scheme. We would probably bring it in through a staged process. I know that you have received conflicting evidence—you have just described the situation in Scotland—so maybe the best way to do it would be through a staged process with a robust evaluation, at the end of every stage, of how it is working out. We are also working with pharmacists on chronic conditions, but I am focusing on the minor ailments scheme much more at the moment.

[92] **Kirsty Williams:** In your paper, you say that developments in this field since 2005, which we all believed would be the step change that was needed to change how community pharmacies worked within the NHS, have ‘not been quick enough’. What do you believe have been the barriers that allow you to make that statement? You go on to say in paragraph 6.2, that the

[93] 'Welsh Government will shortly consult on changes to the pharmaceutical regulations'.

[94] We have heard a great deal about that in evidence. What do you mean by 'shortly', and what are the timescales for the work? When do you expect to begin the consultation? When will it end? When will we see new regulations? In answer to Vaughan Gething, you said that you have 'more or less decided' that the minor ailments scheme will be an all-Wales scheme. When will you be in a position to have made up your mind completely, rather than more or less, so that we have an expectation of what the minor ailments scheme may look like?

[95] **Lesley Griffiths:** On the barriers, the problem is that you have different groups of professionals who think that they can do it the best way. It is a matter of ensuring that everyone works as a seamless primary care team. I will bring in Gwyn on this, but one barrier is the IT system and ensuring that the right professionals access the right information at the right time. There are several barriers. We now have the structure in place with the local health boards to be able to have that seamless team. It is a matter of bringing everyone together, realising that everything has to be done for the good of the patient and everyone has to pull in the same direction. Those are the barriers. I will bring Gwyn in later on the IT aspect.

[96] I recognise that the existing regulations are in need of reform. I am currently looking at papers. I would like to go out to consultation next month, and then we will go through the consultation period.

[97] You asked about the minor ailments scheme. I would imagine that I will be able to make an announcement within a month.

[98] **Kirsty Williams:** So, in February, we can expect a comprehensive announcement on a minor ailments scheme and we can look forward to beginning the consultation on the regulations.

[99] **Lesley Griffiths:** Yes.

[100] **Kirsty Williams:** So, when would you expect the regulations to be finalised? We will have to wait to see what process they will go through, but when will the regulations be passed?

[101] **Professor Walker:** We are looking towards the end of the year.

[102] **Kirsty Williams:** So, is that December 2012?

[103] **Lesley Griffiths:** Yes.

[104] **Professor Walker:** We will be going out to consultation in February. We will be revising the regulations that we are putting out to comment. We will be testing them out within the system, and then, hopefully, finalising them by December. That is the timetable that we are working to.

[105] **Kirsty Williams:** What would you say would be the principal effects of the changes in regulations that you are hoping to achieve?

[106] **Mr Evans:** Primarily, we are looking to simplify the arrangements for control of entry, which is the process by which pharmacies apply to either join a pharmaceutical list or move from one location to another. We recognise that the primary regulations date back to

1992; they have been amended several times, so there is great benefit in revoking and consolidating them and providing them in a simpler format that will improve interpretation. Primarily, our aims are to simplify the existing arrangements for control of entry, although we will also consult on the potential for future changes to move to a different system of control of entry, based on a formal pharmaceutical needs assessment. We would not be able to make that change to regulations currently, as we believe that it needs a change of primary legislation. Subject to the consultation and the views of all stakeholders, we may seek to make changes to primary legislation in the future.

[107] **Darren Millar:** The Minister will be aware that we have corresponded on a particular issue in my constituency about moving a pharmacy from one location to another, which has been going on now for years within the application and appeals process; as I understand it, it is still not quite concluded. Will the new regulations specify clear statutory timescales by which applications, approvals, appeals, and so on will need to be concluded?

10.45 a.m.

[108] **Mr Evans:** There will not be, as part of the consultation, a specific question asking people to limit the amount of time that it takes to deal with an application, although we will issue comprehensive guidance with the new regulations that will specify to health boards how quickly we believe they should deal with applications. Appeals are often complex. They take time to work through. I appreciate that some have taken a long time in the past, but that system is improving. As part of the consultation we will look to simplify the arrangements for minor relocations of pharmacies so that the current restriction, whereby a pharmacy moving between neighbourhoods, to use the technical term in the regulation, is prohibited as a minor relocation. We are looking to simplify that so that, where an applicant would be able to demonstrate that the same population would be served in a new location, then that relocation would be allowed to be considered as minor, and would move through a simpler process and be resolved more expeditiously.

[109] **Darren Millar:** Why are you not wanting to introduce some statutory timescales?

[110] **Mr Evans:** The legal issues around dealing with appeals need time to work through. It would be difficult to place arbitrary timescales on those. That is not to say that we would not want to deal with appeals in a timely manner. Setting that out in guidance so that people have a reasonable expectation of how long it would take to deal with an application is a more appropriate way of dealing with it.

[111] **Darren Millar:** So, the two-year appeal process, which is still not concluded in my constituency, would be allowed to continue, effectively, even under the new arrangements.

[112] **Lesley Griffiths:** I have asked lawyers whether there is any way to improve that. I was shocked at how long the appeals took, but, certainly, it is the legal issues that are the barrier to having a shorter appeal time. As you say, some of them go on for years, literally.

[113] Kirsty asked about the barriers, and I feel that the NHS Wales Informatics Service is a huge lever that would help on this, so I would like to bring Gwyn in on that.

[114] **Dr Thomas:** It is customary for the IT to be seen as a barrier, but, actually, it is a huge enabler. The answer to the question is the creation of the single electronic record, and to make that available wherever care is delivered. That is our direction of travel, and has been for the last four or five years, since the informing healthcare programme was set up. It is an easy thing to say, but incredibly difficult to do, for lots of reasons that we do not have time to go into today. One of them is that we are not starting with a green-field site; we have decades of legacy systems, hundreds of systems, and the data about the individual patient are scattered

throughout the NHS. It is very difficult, technically, to bring that to a single place at any point in time. We have made huge progress on that front. We are not there yet, and, to some extent, it is a journey that will never end. However, we now have people across Wales on a common infrastructure, so pharmacists are on the broadband network, and everyone is on a common e-mail system—which might sound underwhelming, but it is a huge achievement just to get that basic platform in place. A house sinks or swims on the quality of the sanitation, so that is in place.

[115] The real issues of resistance to change are around human behaviour, because the IT really only works if things are standardised. Issues of trust, access, authentication and authorisation—who is trusted to view this information and where—are entirely a matter for the clinical professions and the patients to sort out. I will give you one example where we have made huge progress, and that is on something called the individual health record. I think that we now have about 2 million patient records that are available to be shared. The clever bit is not the technological solution, because the information is already in the GP systems. The problem has been that, although those systems are very good, they were never built to share the information outside individual practices. We now have around 2 million of those records technically available to be shared in an out-of-hours, emergency care setting. That restriction is defined entirely as a boundary of trust between the clinicians and the patients. There is technologically no reason why we could not make that record available wherever—to pharmacists, nurses, social workers, or whomever. It is not a technological problem; it is a behavioural and social one.

[116] The last point that I would make on this subject is that we have set up the Welsh information governance board, which is independently chaired. It was set up by the Minister last year. That has representatives from all of the clinical professions—from the British Medical Association, the Royal College of Nursing and the community health councils. We also have legal and ethical expertise and representatives from the voluntary sector. In a sense, that is the independent body that represents the public interest in striking the right balance between information sharing and keeping important things confidential. We have the machinery and the mechanism; we now need to rally around something that gives benefits to patients. That could be chronic disease management or minor ailments, but we need a patient-based objective in order to unlock this tangle of behaviours. We have to shift this debate away from the risks and problems of sharing to the benefit to the patient. That is, to consider the risks of not sharing information as opposed to the risks of sharing.

[117] **Lesley Griffiths:** So, the technology is there.

[118] **Dr Thomas:** Yes.

[119] **Mark Drakeford:** We have certainly heard quite a lot of evidence that would lead you to understand that sorting out relationships between professional groups on the basis of trust and sharing is key to making some progress.

[120] **Lesley Griffiths:** As well as ensuring that the public has confidence in the system.

[121] **Mark Drakeford:** Yes, we have heard that too.

[122] Vaughan, you wanted to say something on this particular point.

[123] **Vaughan Gething:** Yes. Do you see registration as helping in the sharing of information to try to get over some of those barriers? We heard very clearly about barriers and the unwillingness of some professional bodies to share information or to give information that they want to hold. However, do you see a role for registration to help to work through some of those problems? That is, registration at a practice or pharmacy might make it easier

to cut through these problems.

[124] **Lesley Griffiths:** Yes, I do, which is why I am so keen to do that. As Gwyn said—I should not have said that it is a barrier—IT is a great enabler. That is why I am so keen to see the registration of patients with a pharmacy within the minor ailments scheme. Most GP surgeries tend to use one pharmacy. We need to look at what someone can do if they are on holiday or are in another part of Wales and therefore unable to access the pharmacy where they are registered. We need to ensure that that is bottomed out as well. However, I think—I hope that Gwyn will back me up on this—that the registration of patients with a minor ailments scheme in a pharmacy would help to put in place the system that we are trying to develop.

[125] **Dr Thomas:** Things such as that are crucial, because the important issue, from our point of view, in maintaining trust is knowing who someone is. That is, knowing that they are the right patient, knowing that they are registered with a pharmacist or a doctor, knowing that someone's registration is current and that they are trusted and reliable. I mentioned a national e-mail system; the importance of that system was not the e-mail, as such, which was just the benefit that we sold to people. The important thing is the directory of names. So, whenever someone wants to look at a record, we check them against the directory of the e-mail service. We have something similar, which is called a master patient index, which will identify unambiguously who the patient is. Clearly, when we are dispensing drugs, that is absolutely crucial. Giving someone the wrong drug could lead to severe consequences. So, anything that improves that identity management—to use the jargon—must be helpful.

[126] **Professor Walker:** The advantage of having patient registration as part of the process of the patient signing up with a particular pharmacy is that they could, at that point, give their consent to share their medical record as well. That is one way around the problem.

[127] **Lesley Griffiths:** There is another possible advantage. GPs are concerned that, if a patient goes to a pharmacy for advice, they are not then seeing their GP and there could be something much more sinister causing their symptoms. So, it would help if they were registered with the same record.

[128] **Mark Drakeford:** I have a long list of people who want to ask questions, so we will try to move on through a few more people.

[129] **Lynne Neagle:** I would like to ask about minor ailments. We heard some very alarming evidence from the Aneurin Bevan Community Health Council that the minor ailments scheme in Gwent has massively increased the cost of prescribing in Gwent through people inappropriately using the minor ailments service to get medicines that they would normally have bought over the counter. I forget the sum, but it was a huge sum of money—it was millions of pounds. Do you recognise that as a problem? If we are looking at rolling out the minor ailments scheme as a universal service across Wales, what analysis have you undertaken of the likely impact of that on the prescribing budget? Do you see any conflict between that and the other efforts that we are making in some parts of the NHS to reduce prescribing costs through moving to generics and so on?

[130] **Lesley Griffiths:** That is a valid point, and it is something that we have had to consider. We would have to ensure that the cost to the NHS drugs bill was very tightly controlled. We would have to limit the types of drugs that we use and the quantity that could be supplied. We would only be able to supply those medicines that offered the best value for money. I know that Roger used to run a scheme, so I will bring him in, but the evaluations have concluded that it is a very safe and effective service, which is generally very well received by patients. However, it is a scheme that will have to be tightly controlled with regard to looking at the budget for medicines.

[131] That is also why I have come to the conclusion that it should be a staged approach so that we can robustly evaluate at the end of every stage, rather than just have a universal scheme straight away. Perhaps Roger can say a bit more.

[132] **Professor Walker:** The community health council raised the figure of £6 million with you. That figure has been slightly misinterpreted. That is the money that is currently being spent as part of the drugs bill. We know that the drugs bill across Wales is £600 million to £700 million per annum. However, that £6 million is for medicines that are prescribed by GPs but which are also available over the counter. Many of those medicines are essential medicines, and although they may be classed as being over-the-counter medicines, it does not mean that the patient turned up with a trivial ailment, but that they actually needed paracetamol. Paracetamol is a very effective agent, but it is one of the agents that would be classed in that category of an over-the-counter medicine. So, that was slightly misleading. It was factually accurate, and I accept that £6 million is spent in Gwent on medicines that could otherwise be purchased from a pharmacy, but they were prescribed medicines and essential medicines. We have to reflect on the fact that medicines such as paracetamol are used very widely—84 per cent of children receive paracetamol before the age of six months, so we have to accept that.

[133] With regard to the minor ailments scheme, the Minister has outlined that we would have to have a formulary in place. We also need patient registration to stop people from misusing the service. In that way, we can divert some work from GPs; the general literature would suggest that 38% of work could be shifted from GPs to community pharmacy. So, we would probably be supplying the same or very similar medicines, whether it is for verrucas, for pain, for diarrhoea or for head lice—these conditions could be easily transferred. A raft of studies have demonstrated that effectively, and we have also done some work on the forerunner to the current Torfaen scheme, where we split a practice into two so that half the practice could access the minor ailments scheme and half could not. The half that could access the minor ailments scheme made far fewer calls to the GP practice than the half that did not receive access to the minor ailments scheme.

11.00 a.m.

[134] So, we are very comfortable with the evidence base. I can make available to the committee a paper that was published by the *Journal of Public Health* in December, which again showed the financial benefits of operating a minor ailments scheme. It was based on a study carried out in north-east England. It was a relatively small study, but it looked in a detailed way at the different options that patients would and would not have taken. There are always dangers in extrapolating from a paper, but they extrapolated from it across England and calculated a saving to the NHS of £12 million.

[135] **Lesley Griffiths:** It will also free up a lot of general practitioner appointments; it is hard to prove how many, but I have read a figure of 40%. I agree that those GP appointments will be taken up by other people, but they will hopefully need them more.

[136] By their very nature, accident and emergency departments should treat cases that are accidents and emergencies, but we know that people with minor ailments access those departments, particularly out of hours. There are lots of benefits to be gained from such a scheme.

[137] **Mark Drakeford:** We would definitely be interested in receiving that paper.

[138] **Lesley Griffiths:** We will send a copy of it.

[139] **Elin Jones:** Community Pharmacy Wales told us that in England there is a possibility of looking to change the pharmacy contract. Currently, it is an England-Wales contract, and Community Pharmacy Wales was quite keen to see progress on developing a contract or framework for Wales only, which would allow you as a Government to meet more clearly your policy intentions regarding pharmacies and the wider NHS. Do you intend to move along the lines of a Wales-only framework, and do you have a timetable for that in mind?

[140] **Lesley Griffiths:** I do not intend to do that. With the current financial constraints, it is not the right time to have this overhaul of the existing pricing structure. Establishing a separate Welsh pharmacy pricing and funding structure would cost money. We also have a certain amount of flexibility in the current Wales-England scheme. However, I will keep the arrangement that we have under close scrutiny. If I did not think that the people of Wales were being best served by that arrangement, I would obviously take the appropriate action. The framework that we have can provide for a comprehensive community pharmacy service that can integrate with the rest of the healthcare service, particularly in relation to primary care. The 2011 contract marked a step change that acknowledged the dispensing function of pharmacy and built on the delivery of additional services, such as the medicines use reviews that we mentioned, the new discharge medicines review service and our plans to further standardise the enhanced services that we have.

[141] **Elin Jones:** If England intends to move to a new contract—the written evidence from Community Pharmacy Wales tells me that the Secretary of State for Health intends to introduce a separate community pharmacy contract for England—how would you envisage community pharmacy in Wales responding, or how would you respond with your policy on community pharmacy? You spoke of flexibility in the current contract.

[142] **Professor Walker:** We have had discussions with our counterparts in the UK Department of Health, and they have reassured us that we can still move forward on a joint England-Wales basis. We want to deliver the best service for patients in Wales, and I have had discussions with the Minister about that. Our counterparts have reassured us that the contract will be fit for our purposes and will allow us flexibility in Wales, as we had this year when we introduced for the first time targeted medicines use reviews, changes around clinical governance and a discharge medicines review service. These were significant changes for pharmacy and the contract; they are different to those in England, but they fit the bill and the needs of people in Wales.

[143] **Elin Jones:** That is your response. Given the direction of some NHS policy in England, I want reassurance from you, as Minister, that that flexibility allows you enough scope to ensure that the development of services in Wales meets your objectives and ours rather than those of the Government in England.

[144] On a completely different issue, a higher proportion of the under-65 target groups are not accessing their flu vaccinations than those in the over-65 groups. The intention was to allow NHS vaccinations to be given in community pharmacies in some areas, but that did not happen. You say in your evidence that you are still keen for that to happen. Clearly, something did not work out in the relationship between GPs' surgeries—possibly—and community pharmacies. How will you ensure that, next winter, there will not be a repeat of that experience?

[145] **Lesley Griffiths:** You are absolutely right, Elin; there were plans to have it done that way this winter, but the discussions foundered. I have therefore told LHBs that they need to start the process of engaging with community pharmacies much earlier. I think that what happened last time—which was before I took up my post—is that the GPs had put their orders in for vaccinations, and that was one of the reasons the discussions failed. It is important that we learn from that. I am very keen for community pharmacies to do it, because we are not

reaching the target number, as you say, in any of the groups that we need to reach, and if people can access community pharmacies much more easily, that is a good way of administering flu vaccinations. Basically, you are asking me what I am doing. What I am doing is to encourage LHBs to start their talks much earlier than they did last year.

[146] **Mark Drakeford:** Your intention is clear in your report, Minister. So, there is no ambiguity for any of the professional groups this year: you state what you intend to happen.

[147] **Lesley Griffiths:** I am very keen for community pharmacies to be part of the scheme.

[148] **Elin Jones:** That is every LHB area, is it? In your evidence, I think that you say that two LHBs were looking at it this year, but your intention is for it to be an all-Wales scheme, is it?

[149] **Lesley Griffiths:** I have asked every LHB to consider it this year.

[150] **Rebecca Evans:** Minister, you say in your evidence that you are exploring, with Public Health Wales, the role that community pharmacies can play in widening access to healthcare in rural areas. Can you update us on those discussions and the kind of thinking that is coming forward?

[151] **Lesley Griffiths:** Rural areas obviously have specific issues. Clearly, there are rural parts of urban areas as well, and it is important that we have those discussions. As part of the rural health programme, we are considering undertaking a pharmaceutical needs assessment to help with future planning, to see what we need to do specifically. We have dispensing doctors in rural areas as well, which we intend to continue with.

[152] **Rebecca Evans:** That brings me to the other issue that I wanted to raise, namely dispensing doctors. Evidence to the inquiry has suggested that there are great tensions between community pharmacies and dispensing doctors in rural areas. What is your approach to dealing with those tensions?

[153] **Lesley Griffiths:** As I have said, everybody should be working as part of the same team. Dispensing doctors were introduced to ensure the availability of dispensing services in the areas where a community pharmacy is perhaps unlikely to provide them, or where a community pharmacy is unlikely to open because of the volume of prescriptions that it would be dispensing. GPs need to realise that their dispensing fees are not meant or designed to support their medical services; they are an addition. We are therefore looking at the matter very carefully, but we have no plans to abolish the role of dispensing doctors.

[154] **Mark Drakeford:** Kirsty, do you have a point to make on this issue?

[155] **Kirsty Williams:** Not on this point, but if there is time, I would like to say something.

[156] **Mark Drakeford:** Okay, we will do our best. Darren, you have asked your questions on regulation; do you have another question?

[157] **Darren Millar:** I have one on a separate issue.

[158] **Mark Drakeford:** You can ask yours now, and then Mick can come in.

[159] **Darren Millar:** Minister, you have talked about the enhanced service on the minor ailments front, and you have touched a little on chronic disease management. However, in section 6 of your report, you list a number of other services, one of which is health checks for

the over-50s. To what extent do you see community pharmacies being involved in the delivery of that Welsh Government policy objective? Do you expect them to be the lead agency in those health checks, or will it be a GP-led health check programme? To what extent will the cost of providing those sorts of services have an impact?

[160] **Lesley Griffiths:** I am looking at the whole issue of health checks at the moment. I would not expect pharmacy to take the lead. However, I think that it will be an integral part of it. If we have the registration of patients that I want to see, that is something that can happen in community pharmacies. All along, since my appointment, I have said that I want every health consultation to be a public health consultation, and community pharmacy and pharmacists have a role to play in that.

[161] **Darren Millar:** Is the development of the role of community pharmacy in the health checks process in its infancy?

[162] **Lesley Griffiths:** Yes. I am looking at that.

[163] **Darren Millar:** When do you expect to be able to report on its involvement?

[164] **Lesley Griffiths:** I cannot give you a date at the moment, but we are looking at it carefully at present.

[165] **Mick Antoniw:** I will draw your attention to paragraph 1.2 of the written evidence for initial clarification. You describe some of the key features of the 2005 contract and what has been achieved. I am a little concerned that there seems to be an overwhelming acceptance that all these things have been achieved, and some of the evidence we have had is that it is a bit more disparate than that, particularly with regard to things such as standardising information for the public about services offered and so on. Can you expand on what you think has been achieved by the 2005 contract? How confident are you that the achievements are as solid and full as described in the paper?

[166] **Lesley Griffiths:** A great deal has been achieved. There is more to be done; I am not trying to say otherwise. However, a great deal has been achieved. For instance, in 2005, eight pharmacies provided the NHS smoking cessation service, but the figure now stands at 330 pharmacies. In 2005, 88 pharmacies provided emergency hormonal contraception, but 386 now provide that service. The percentage of pharmacies offering supervised administration of substitute medication for opiate addiction was 25%, and now it is 65%. So, a great deal has been achieved. I said at the beginning that the information given to the public is perhaps not as clear as it should be, and we are working on that with stakeholders. We have a lot to be proud of, but there is more to be done. The minor ailments scheme will bring all these things together. So, I do not accept the criticism that there has not been the step change we wanted, because I think that it has happened.

[167] **Mick Antoniw:** One of the key things emerging out of this and some of the evidence we have had is about people's perception of community pharmacy, their understanding of it and the confusion and overlaps surrounding it. What work needs to be done to have a clear pathway for people to understand? What are your plans in terms of putting that across and making that an integral part of health provision in Wales?

[168] **Lesley Griffiths:** It is an ongoing discussion with local health boards. It is up to the LHBs to get that information out. I keep saying this: we need an integrated primary care team. It is about putting the patient at the centre; it is not about barriers, but overcoming barriers. It is about all the different professionals working together. We are getting there, but it is vital that people are not parochial, but work as part of this integrated team. The system we have now with the seven LHBs is our best chance of having the seamless primary care team that I

want to see.

[169] **Mick Antoniw:** I have one point that follows on from that. As part of the expansion—I still have concerns about how clear that pathway is, but that is work in progress—big players moving into the field of community pharmacy are the big corporate organisations, such as Tesco. These are aggressive corporate giants. To what extent does the ethos of this sector impact on your plans? First, are these organisations geared up to the ethos of health provision and the expansion of services and what we want to achieve, as opposed to getting people into stores to make money out of them in other ways? Secondly, will they present a danger to the growth of community pharmacies, because their capacity and expansion in all sorts of areas could unbalance what you are trying to achieve?

11.15 a.m.

[170] **Lesley Griffiths:** I do not have any evidence that large pharmacies do not fit in with our ethos. I will bring Roger in on that. Sometimes, patients feel more comfortable with small, independent pharmacies. However, all pharmacists have a role to play.

[171] **Professor Walker:** Currently, 64% of all contractors in Wales are classed as multiples. The evidence that we have from a professional perspective is that they offer excellent services. From the perspective of the Welsh Government, and the new services that it has introduced, uptake has always been more rapid within the multiples than the smaller independents. They rise to the challenge that has been set. They are very responsive. Clearly, they have a commercial interest, but they have a lot of support to direct it in a professional direction as well as a non-professional direction, shall we say. My comments about their contribution to the NHS in Wales are positive.

[172] Going back to your earlier issue on signposting and the clarity of services offered through community pharmacy, I am conscious that we have to do more. We have to work with LHBs to do more in that area. A good example in my opinion—although you may disagree—is the delivery of the roll-out of the national scheme for access to emergency hormonal contraception. We required that all pharmacies that deliver it have a private consulting room, that the medication is administered on site and that the patient, the individual woman, has a detailed consultation with the pharmacist. The most recent figures that we have of the last three months show that almost 8,000 units were issued through community pharmacy, compared with less than 3,000 through GP practices. GP practices are now referring women to pharmacies, because they know that they will have more rapid access. We have talked about minor ailments; EHC is a level up from that, because it is a very personal and confidential issue. It reflects the fact that patients and women have confidence in their community pharmacy. Community pharmacy is now the preferred supplier.

[173] **Lesley Griffiths:** We had a single national specification for emergency hormonal contraception, and I would like to see that for the other enhanced services. That service proved that community pharmacy services could really step up to the plate. I am sure that we will see that being rolled out with the other enhanced services as well.

[174] **Mick Antoniw:** The expansion of the role of community pharmacies, and the increased encroachment into more medically complex areas that may overlap into other conditions, requires far greater quality monitoring, for a variety of reasons. Will the proposed regulations that we have been talking about seek to impose a far more rigid monitoring system?

[175] **Professor Walker:** The regulations are for the regulation of professional practices. It is carried out by the general pharmaceutical council, which regulates pharmacies. It monitors individual performance, along with the LHBs. We need to move towards a fitness-to-practice

list for pharmacists, as we already have for GPs. That is an issue that we are also looking at.

[176] **Mark Drakeford:** I will go to Lindsay and Kirsty next, but we have time for one quick question from me. It follows up on the point that Mick made on dealing with the conglomerates. Dr Thomas, you might know, do they throw up particular challenges in relation to information exchange? If you are trying to set up a system while dealing with large organisations that have very sophisticated information systems of their own, does the interface between them and the NHS throw up particular issues compared with a more traditional community pharmacy?

[177] **Dr Thomas:** At a technological level, probably not—as long as we are all on the same infrastructure, the same network, the same data storage, and so on. There will be issues about the technical standards that they use versus the ones that we use. I am confident that the technological problems are solvable. Just by coincidence, I am arranging to see the chief information officer of Tesco in a couple of months' time. The issue of moving information across that boundary is going to increase.

[178] **Lindsay Whittle:** I will have to read this question, or otherwise I will get all the right words but not necessarily in the right order: on the supervised administration of substitute medication for opiate addiction, it is good news that the percentage of pharmacies offering this has risen to 65%, but are there any plans to roll that out even further? It is very important. To refer to Mick Antoniw's idea about Tesco and Asda—other supermarkets are available—are those conglomerates able to offer such a facility? Needle exchange is a good thing as well, but I am particularly concerned about having a good campaign to wean people off this terrible addiction, and this will help enormously throughout all our communities and make them much safer as well as making the individuals far safer, because, after all, these people are victims.

[179] **Lesley Griffiths:** Basically, it is up to local health boards which pharmacies provide the services. I do not tell local health boards that they must offer this in every pharmacy; it is really up to the LHBs, and that applies to the larger pharmacies as well.

[180] **Lindsay Whittle:** I did not know that.

[181] **Professor Walker:** They usually allow the manager within each branch to make the decisions based on local need. Again, part of the decision has always rested with health boards in the past because, in many situations, there may be two pharmacies in close proximity, and there is a certain amount of logic to providing the service in only one of those pharmacies. On the issue of signposting, to pick up on the point made earlier, it is very important for people to know what services are provided by which pharmacies.

[182] **Lindsay Whittle:** Chair, there is greater anonymity in using a large supermarket rather than using the pharmacy in their town or village.

[183] **Professor Walker:** There is, but we have also got to bear in mind with, for example, the supervised administration of methadone, that the community pharmacist may be sitting in very close proximity to the individual for five or ten minutes daily while they consume the medication. Part of the supervised administration is to have a discussion, because, in that way, they have to swallow it; the individual cannot secrete it and store it in their mouths and then take it out of the premises. Pharmacists, whether they are from big multiples or independent pharmacies, have a very close, detailed and often intimate contact with substance misusers.

[184] **Lindsay Whittle:** I cannot say that I have noticed whether there is a private room for people in supermarket pharmacies. There may be and I may just not have noticed them. I will pay special attention next time I am shopping.

[185] **Professor Walker:** Some 650 of our community pharmacies now have private consultation rooms, and 588 that we know of have been registered with the health boards. However, they can also self-certify. We know from the data that the majority of pharmacies across Wales now have private consultation areas, which can only be of benefit to patients.

[186] **Lindsay Whittle:** And the supermarkets?

[187] **Professor Walker:** Yes the supermarkets do as well.

[188] **Lindsay Whittle:** I will check that. Thank you.

[189] **Kirsty Williams:** We have seen in the evidence that the local health boards' enthusiasm for pursuing the opportunities made available to them by the 2005 contract has been quite poor. The oral evidence that we have received from the LHBs indicated that the opportunities simply have not been taken up. Minister, today, on a number of occasions, you have said, 'Oh well, this is a matter for the local health board', and on some occasions you have also said that it is your intention that enhanced services should be available nationwide. Those are quite contradictory—

[190] **Lesley Griffiths:** No, I did not say that—

[191] **Kirsty Williams:** Well, I will check the Record. I am keen to understand from you what the balance is in your approach between continuing to allow local health boards to commission services that are deemed fit for their local populations and your determination to have Wales-wide services so that your vision for community pharmacy is achieved. I would be interested to know what balance you are seeking to strike between allowing local health boards to take the lead and dictating and creating national initiatives in which everyone will have to take part.

[192] **Lesley Griffiths:** To clarify, I said that I do not tell LHBs that they must have every service in every pharmacy. The most important thing about universality is best practice—that is something that I do tell LHBs. Where there is not best practice or where the best services are not provided, they have to justify to me why they are just accepting that. So, it is up to the local health boards, as I cannot micromanage the NHS. It is up to LHBs to provide the services that they think are needed for their local population. I can advise and set the policy, but it is up to LHBs to decide how they put those services in place for their local population. As I have said several times, community pharmacies are part of an integrated team, and it is about everyone pulling together. I do not want to see professional groups working in silos—I want to see that integrated primary care team.

[193] **Kirsty Williams:** If that is your approach, the list of things in point 6.1 may or may not happen. So, when you say that you are 'establishing'—which is a pretty definite statement—and developing this and that, those are your aspirations but it will be up to the LHBs whether these things exist within their local areas.

[194] **Lesley Griffiths:** The only thing that I have said in this evidence session that I want to see universally is the minor ailments scheme, and I am working towards that. However, it is up to the local health boards to decide—I advise them, I set the policy and I set the direction. For instance, as Roger said, if you have two pharmacies in close proximity, is it the right thing to have the same services in both pharmacies? So, it is up to the local health boards to decide; I do not know where all the pharmacies are based.

[195] **Professor Walker:** Part of the challenge has been on professional issues within pharmacy and LHBs, where we have had different standards of training in the past for EHC

between one LHB and another, for example. Those are issues on a professional level where we have standardised training so that pharmacists can move between areas to provide the same service. So, that conflict has existed, and it is an area on which we are working within the profession to address.

[196] **Mark Drakeford:** Diolch yn fawr **Mark Drakeford:** Thank you for coming
ichi am ddod yma'r bore yma. here this morning.

[197] We have had a very good run round the table, but if there is anything that you have not been asked or any final points that you want to make sure that you get over to us, you have a minute to do it. However, you may feel that everything that needs to be said has been said.

[198] **Lesley Griffiths:** I cannot think of anything offhand.

[199] **Mark Drakeford:** Thank you all; that was a very helpful session to us. That concludes the formal part of our business. Any Members who would like to stay for another half an hour to discuss issues of co-responders, and whether there is any work that we need to think about doing in that area, with Professor Siobhan McClelland are welcome to do so.

Daeth y cyfarfod i ben am 11.28 a.m.
The meeting ended at 11.28 a.m.