Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Mercher, 2 Tachwedd 2011
Wednesday, 2 November 2011

Cynnwys
Contents

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Ymchwiliad i'r Cyfraniad a Wneir Gan Fferyllfeydd Cymunedol i Wasanaethau Iechyd yng Nghymru:Tystiolaeth gan BMA Cymru Wales, Cymdeithas y Meddygon Fferyllol a Choleg Brenhinol yr Ymarferwyr Cyffredinol
Inquiry Into the Contribution of Community Pharmacy to Health Services in Wales: Evidence from BMA Cymru Wales, the Dispensing Doctors' Association and the Royal College of General Practitioners

Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Inquiry into Stroke Risk Reduction—Evidence from the Minister for Health and Social Services

Ymchwiliad i'r Cyfraniad a Wneir gan Fferyllfeydd Cymunedol i Wasanaethau Iechyd yng Nghymru: Tystiolaeth gan Gynrychiolwyr y GIG
Inquiry into the Contribution of Community Pharmacy to Health Services in Wales: Evidence from NHS Representatives

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

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
Gwyn R. Price	Llafur (yn dirprwyo ar ran Mick Antoniw) Labour (substituting for Mick Antoniw)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr David Bailey	Cadeirydd, Pwyllgor Ymarfer Cyffredinol Cymru, BMA Cymru Wales Chair, General Practice Committee Wales, BMA Cymru Wales
Dr David Baker	Prif Weithredwr, Cymdeithas y Meddygon Fferyllol Chief Executive, Dispensing Doctors Association
Lesley Griffiths	Aelod Cynulliad (Llafur), Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Assembly Member (Labour), Minister for Health and Social Services
Dr Tony Jewell	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Dr Chris Jones	Cyfarwyddwr Meddygol, GIG Cymru Medical Director, NHS Cymru
Chris Martin	Cadeirydd, Bwrdd Iechyd Lleol Hywel Dda Chair, Hywel Dda Local Health Board
Dr Paul Myers	Cadeirydd Etholedig, Coleg Brenhinol yr Ymarferwyr Cyffredinol Chair Elect, Royal College of General Practitioners
Dr Berwyn Owen	Bwrdd Iechyd Prifysgol Betsi Cadwaladr, a Chyfarwyddwr Rhaglen Cenedlaethol Rheolaeth Meddyginiaethau Betsi Cadwaladr University Local Health Board, and Director of the National Medicines Management Programme
Bernardine Rees	Cyfarwyddwr Gweithredol, Gofal Iechyd Sylfaenol, Iechyd Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Lleol Cwm Taf Executive Director of Primary, Community and Mental Health Care, Cwm Taf Local Health Board
Dr Philip White	Trafodwr, Pwyllgor Ymarfer Cyffredinol Cymru, BMA Cymru Wales Negotiator, General Practice Committee Wales, BMA Cymru Wales

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

Steve Boyce	Ymchwilydd Researcher
Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Victoria Paris	Ymchwilydd Researcher
Naomi Stocks	Clerc Clerk

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Croeso i bawb. Yr ydym yn gweithredu'n gwbl ddwyieithog, felly os oes unrhyw un eisiau defnyddio'r Saesneg neu'r Gymraeg, mae'n agored i bawb wneud hynny.

Mark Drakeford: Welcome to this meeting. We operate totally bilingually, so if anyone would like to use Welsh or English they are welcome to do so.

9.31 a.m.

Ymchwiliad i'r Cyfraniad a Wneir Gan Fferyllfeydd Cymunedol i Wasanaethau Iechyd yng Nghymru:Tystiolaeth gan BMA Cymru Wales, Cymdeithas y Meddygon Fferyllol a Choleg Brenhinol yr Ymarferwyr Cyffredinol
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[2] **Mark Drakeford:** Bore da a chroeso i aelodau'r panel. Diolch i chi am ddod. Yr ydym yn bwrw ymlaen y bore yma gyda'n hymchwil i fferylliaeth gymunedol yng Nghymru. Croeso i Dr David Bailey, cadeirydd Pwyllgor Ymarfer Cyffredinol Cymru a Dr Philip White. Yr ydym wedi siarad â Dr White yn barod; ef yw trafodwr Pwyllgor Ymarfer Cyffredinol Cymru. Croeso i Dr David Baker, prif weithredwr Cymdeithas y Meddygon Fferyllol a Dr Paul Myers, cadeirydd etholedig Coleg Brenhinol yr Ymarferwyr Cyffredinol. Diolch yn fawr iawn i chi gyd am ddod. Dr Bailey, gofynnaf i chi ddechrau gyda rhai sylwadau byr, ac wedi hynny bydd cyfle i aelodau'r pwyllgor ofyn cwestiynau i unrhyw aelod o'r panel. Byddaf yn troi atoch chi, David, i ofyn i chi gyfeirio'r cwestiynau at yr aelod mwyaf

Mark Drakeford: Good morning and welcome to the members of the panel who are before us today. Thank you all for coming. We will continue this morning with our research into community pharmacy in Wales. Welcome to Dr David Bailey, who is chair of the General Practice Committee Wales, and to Dr Philip White. We have already spoken to Dr White; he is the negotiator for General Practice Committee Wales. Welcome to Dr David Baker, the chief executive of the Dispensing Doctors' Association and Dr Paul Myers, the chair elect of the Royal College of General Practitioners. I thank you all for coming. Dr Bailey, I will ask you to start with some brief comments, and there will then be an opportunity for committee members to ask questions of any member of the panel. I will

addas o'r panel i ateb. Ni fydd amser i bob aelod o'r panel ymateb i bob cwestiwn.

turn to you, David, to ask you to direct the questions to the most appropriate member of the panel. We will not have enough time for every member of the panel to answer every question.

[3] David, will you give us a few introductory remarks?

[4] **Dr Bailey:** Yes, absolutely. When you are asking whether we are for or against professional co-operation, it is a bit like asking whether we are for or against Christmas. Clearly, we are for professional co-operation. Our concern about some of the work that is going on in pharmacy at the moment is whether it will destabilise dispensing practice in rural Wales. At the end of the day, if you have a GP, but no pharmacist, you still have a primary care service. If you have a pharmacist, but no GP, you basically have a corner shop. So, there is a real problem if dispensing practices, which subsidise the general medical service by dispensing, are destabilised if new pharmacy organisations move into rural areas. So, we have a concern about that.

[5] In terms of professional co-operation, clearly we are in favour of closer co-operation with our pharmacy colleagues. There are ways that we can work together more closely. You have mentioned things such as minor ailments specifically. There are some elements of minor ailments and screening where it would be helpful to have a closer working relationship with pharmacists. It is probably fair to say that, on the ground, most GPs have a close personal relationship with their local pharmacy. That has been the case for generations, because they work together every day. I speak to the pharmacists in my health centre virtually every day. You cannot work in isolation. However, we are keen that any policy changes do not impact on the provision of basic general medical services in rural Wales.

[6] **Mark Drakeford:** That is helpful as a starting point. It was remiss of me at the beginning not to welcome Gwyn Price who is substituting today for Mick Antoniw. Welcome to your first meeting of the Health and Social Care Committee. I should also have mentioned that we have received apologies from Darren Millar, who is—

[7] **William Graham:** He is in hospital in South Africa.

[8] **Mark Drakeford:** Indeed. It is a long way to go to avoid the NHS, is it not? [*Laughter.*]

[9] **Gwyn R. Price:** He really needs a doctor. Do you think that pharmacy and GP contracts help or hinder?

[10] **Dr Bailey:** You would expect me to say this: I think the GMS contract for GPs helps. It has delivered a much more consistent service over the past 10 years in providing public health measures through the quality and outcome framework and is continuing to develop. Mark will probably know that, about 35 minutes ago, we announced an agreement between us and the four Governments for the next 12 months that, I think, will continue to deliver decent general medical services. We are comfortable with where we are on that.

[11] On the pharmacy contract, the new things in the contract are helpful because they are looking to mould it a little bit in the same way as the GMS contract, whereby enhanced services, such as help with smoking cessation and tackling substance abuse, are provided via pharmacies. Those are two areas where pharmacy can improve primary care services, and I think that the new contract for pharmacists helps with that. The only issue we have with the current way that the pharmacy contract is being negotiated—and this is not any criticism of pharmacists, but, I am afraid, of Government—is the fact that they are using the prices of

drugs to move money around within the pharmacy contract through the category M system. Unfortunately, they negotiate with the pharmacist to move money for extra services into the pharmacy contract, but the price that is altered actually affects dispensing doctors in exactly the same way and they have no means of re-earning that money. So, that is a financial pressure on dispensing doctors. That is a potential issue for us, and it is becoming a greater issue as category M expands.

[12] **Gwyn R. Price:** So, you are saying that you are reverting to being a catalogue—sometimes it is up, sometimes it is down, and then you go somewhere else where it is cheaper—

[13] **Dr Bailey:** No, what happens with category M is that they revise the prices of a basket of important basic drugs to pharmacists—lower the prices basically—and renegotiate that in so that they can deliver enhanced services. That is a perfectly reasonable thing to do in isolation, and we would not dream of interfering with the way in which pharmacists negotiate with Governments, but the problem is that that has an unintended consequence—or possibly an intended consequence—of taking money out of dispensing, and there is no means for dispensing doctors who, at the moment, dispense about 10 per cent of all prescriptions in England and Wales, to earn that money back.

[14] **Gwyn R. Price:** I think that it all revolves around value for money, really. Perhaps, in the past, they were not getting value for money, and perhaps this is a way of moving forward. Thank you for your answer.

[15] **Mark Drakeford:** I will now ask for questions from William Graham, then Vaughan, and then Kirsty.

[16] **William Graham:** I want to ask you about rural health services, which are mentioned in your paper, having had an excellent experience of dispensing in a rural practice. I am particularly interested in your views on what will happen if these services are extended. What will really happen to doctors' practices when the community pharmacy is or is not able to react within a rural community?

[17] **Dr Bailey:** The problem with moving community pharmacy into rural areas—and I am sure that Paul and David will both want to reply on this as well—as has been demonstrated recently in the cost of service inquiry that was done in England, is that, particularly in rural areas, the dispensing part of general practice subsidises the GMS part. Our concern is that, because these are usually small, spread out practices with very little opportunity to federalise and co-operate with other practices as they might be 30 or 40 miles away, anything that destabilises the core income of the practice may make it unviable. I suspect that both my colleagues will want to reply to that as well.

[18] **Dr Myers:** Yes, I would certainly confirm that. Some of the very rural practices' income in terms of their ability to provide sufficient staff is very dependent on the income from dispensing. The concern would be that, if that income dropped, they would need to reduce the number of staff, which would have an impact on the quality of care for all patients, not just those being dispensed to.

[19] **Dr Baker:** I would echo David's and Paul's comments. The problem is that, although dispensing was never designed to subsidise rural medicine, the fact is that it does. About half of the profit, if you like, that comes in from dispensing is reinvested in rural services generally. The sort of things at risk are branch surgeries, which become unviable as dispensing income falls, and it is falling quite dramatically, as David said, because of the unintended consequences of category M and, recently, the special deal that has been made in the pharmacy contract.

[20] **Mark Drakeford:** Does anyone else have a question on this issue of dispensing doctors because, if not, we will move on to other topics? I do not want to keep crossing back to it. Kirsty, I know that you had a question.

[21] **Kirsty Williams:** I know a little bit about doctors' surgeries in rural areas. In your paper, you say that dispensing can provide a sizeable proportion of a practice's resources. How much does it provide? What is sizeable?

[22] **Dr Bailey:** That is an almost impossible question to answer because dispensing practices vary so much between a practice of 10,000 dispensing for 1,500 and a practice of 3,000 dispensing for all of them. In that latter practice, they would probably become unviable. In the former practice, they would certainly feel the pinch significantly, but it would not be anything like such a big deal. So, it very much depends on the situation. The cost of service inquiry suggested that the smaller you are, and the smaller your dispensing list, the less likely you are to make any profits. However, medium-sized practices certainly rely on the profits from dispensing to subsidise their general medical services. It is a difficult question to answer.

[23] **Kirsty Williams:** I appreciate that it is difficult, but that is quite a sweeping statement that you have made in your evidence and, when we get evidence like that, we like to see it backed up with some hard and fast analysis of what 'sizeable' actually means. There are probably different opinions right around the table as to what 'sizeable' means. If it was possible to have some better understanding of exactly the kind of impact that we are talking about, that would be very helpful. In terms of the numbers of practices in Wales, how many practices in Wales are dispensing? What kind of locations are there? For instance, if I think of my own area, the main surgeries, even though some of them would be dispensing, would all have access to community pharmacists in the market towns—Brecon, Rhayader, Llandrindod, Builth Wells and Presteigne all have pharmacies in those towns. As you say, some of the branch surgeries—Sennybridge, for example—would not have access to a pharmacy in the immediate area. So, I am trying to get an idea of the scale here as to how many doctors' surgeries are prescribing that would not already have a pharmacy in their market town.

[24] Also, you talk about very rural practises being 30 or 40 miles away from another practice. I represent a big chunk of Wales that is very rural and I cannot think of any practice that is 30 or 40 miles from the next one. I wonder whether we can have a map, Mark, of where this provision is and where these very remote rural practices are to get a better understanding. We would not want to promote any policy to Government that would destabilise rural practice, but, at the moment, we do not have enough basic information in front of us about what the current pattern of provision is.

[25] **Dr Bailey:** I will answer the first couple of questions and I will then hand over to David, who is the expert in this field; I am not a dispensing doctor, but David is and spends his full time doing that. There are about 90 practices in Wales that dispense or partly dispense. Some of those will be dispensing under the one-mile rule, which basically means that they dispense to their more rural patients. I am sure that you understand that, Kirsty, but I am just explaining it to everyone else. Others are in small villages of less than 3,000 people where they may well dispense to everyone and may well be far more than that distance away from the nearest pharmacy. You will forgive my slight hyperbole with the 30 to 40 miles, but there are significant distances between—

[26] **Kirsty Williams:** I am afraid that we cannot deal in hyperbole; we deal in facts.

[27] **Dr Bailey:** A politician getting rid of any hyperbole is an interesting concept. Perhaps I should ask David to answer, who has a far more detailed understanding of the finances of

this.

[28] **Dr Baker:** You flatter me. There are 89 dispensing practices in Wales; that is, about 18 per cent of all Welsh practices dispense to their patients. They do not do a huge number of prescriptions—about 7 per cent of all prescriptions are dispensed by dispensing doctors rather than by a pharmacist. The one thing that has not been mentioned by either of my colleagues is patient choice. As you know, in rural areas where dispensing has happened, when a pharmacy comes into the area, the doctor has to cease dispensing to anyone who lives within a mile of that chemist.

9.45 a.m.

[29] Patients do not like that. They do not like the change; they like the one-stop shop. In 2008, there was a move in the health Bill in England—I do not think that it covered Wales—to change the criteria from being the distance of a patient to the pharmacy, to the distance of a surgery to the pharmacy. So, that one-mile rule was about the distance from surgery to pharmacy not from patient to pharmacy. That caused uproar, and 62,700 patients wrote to the department—it was the biggest response that it had ever had—to say, ‘Please don’t do this’. We are not looking for a monopoly; we want to work closer together to allow the regulations to permit co-operation, collaboration and even co-location with pharmacy. We want to work together, with the patients’ interests, not necessarily our interests or those of the pharmacist, being paramount. Patients and patient choice must come first.

[30] **Mark Drakeford:** Thank you for those comments, Dr Baker. You have mentioned some helpful facts. We may ask our clerk to speak to you outside of the meeting to see whether you have more of that sort of basic information, besides what you have just said, to help us in thinking about this.

[31] **Dr White:** I am a dispensing doctor as well, and as Kirsty appears to require some ballpark figures, I can say that we use our dispensing income to subsidise a full partner in practice. We are almost four partners in a practice with 5,500 patients. One partner is paid for by the dispensing income, and were that income to disappear, we would effectively need to reduce by one partner and reduce services.

[32] **Mark Drakeford:** Thank you. We have given the dispensing issue a good run in the time that we have. We will now move onto some other issues. Vaughan?

[33] **Vaughan Gething:** Kirsty was remarkably polite to you. When I read your evidence, I was remarkably unimpressed. I am really not impressed with the way that the evidence has been set out. You have also avoided answering on significant points in the inquiry, although you have answered points that we have not asked about. You talk about the entry regulations, but we are not talking about changing those at all. I was surprised that you did not mention the joint statement between the Royal Pharmaceutical Society and the Royal College of General Practitioners, which talks about closer working practice. One of the questions that we asked the Royal Pharmaceutical Society when it was here was, ‘How and why has it taken us so long to get here?’, and you have not even addressed that. That is really not impressive. I would like you to take seriously what we are doing, rather than giving us all of this hyperbole, and just answer the questions.

[34] You have spoken about wanting to work more closely together to arrive at better patient outcomes, but where is the evidence for that in your paper or in the suggestions that you make? You said in your introductory remarks that you would be interested in looking at minor ailments schemes. That is a specific point in our inquiry terms of reference, but you do not answer that in your evidence. I want to know why that is and what you really think about what we could do with these services to deal with the points that are covered in the terms of

reference for the inquiry. It is all very interesting, but it has nothing to do with the recommendations that we are going to make.

[35] **Dr Bailey:** To briefly answer that, as a trade union, we have a responsibility to our members, and there is a particular interest here for dispensing doctors. On your question about the idea of co-operation, we have had conversations over the past two or three years with CPW and we have also been involved in discussions with Government about whether we could start to introduce minor ailments schemes. There were some interesting schemes in Scotland, where pharmacists were used to treat minor urinary tract infections, and we were supportive of trying to introduce that about two years ago. However, nothing came of that work, because there was no funding to support it. We would still be supportive of certain minor ailments schemes coming in—the treatment of UTIs and smoking cessation schemes are possibilities, and, from a public health point of view, probably offer the biggest opportunity for using community pharmacists on a wider scale. We have already seen what happens with emergency contraception and expanding that service. We have been supportive of that, although we have some reservations with regard to communication. The difficulty with pharmacists treating minor ailments—going too far—is that pharmacists are not trained to diagnose. There are some elements, such as smoking cessation, where that is not an issue. There will be other elements, such as minor respiratory illnesses, where there is a potential problem. We have to consider patient safety as the important thing, and I would not want to see minor ailments go to an extent where you were reliant on a pharmacist who has not been trained to diagnose illness. So, there are limitations there. I suspect that Paul will want to say a little regarding the joint statement from the Royal Pharmaceutical Society and the Royal College of General Practitioners.

[36] **Dr Myers:** That joint statement from the Royal Pharmaceutical Society and the Royal College of General Practitioners was published in August this year. It was entitled 'Breaking down the barriers—how community pharmacists and GPs can work together to improve patient care'. I believe that the Royal Pharmaceutical Society witnesses mentioned it when they give evidence. This statement recognises the point that you have made, namely that it is taken some time to get to this point. There have been traditional professional barriers between the professions over the years, but the approach from both GPs and pharmacists now is that we are both in primary care together and that we can collaborate. This statement confirms the wish of the two professions to collaborate more and gives some examples, not in any detail, of how the two professions can work together. As David said, there are already instances in Wales of collaboration. In our practice, we share information, and we will now report significant events. For example, where there has been a near miss, either in the surgery or in the pharmacy, we will now share information on that. Pharmacists will come to some of our practice meetings. The culture of sharing is beginning.

[37] We have met the Royal College of General Practitioners Wales and the Welsh branch of the Royal Pharmaceutical Society to have an initial meeting to look at this document and how we can put it into action in Wales. We do not have any firm plans at the moment, but we are working on that.

[38] **Vaughan Gething:** That is disappointing, because there have been years of new contracts coming in with supposed opportunities, and you are telling us that you are talking about it now. You say that you want to have greater co-operation, but your evidence reeks of protectionism and it does not say that you actually want to co-operate at all; it says exactly the opposite. So, I would be interested in your answering some of the points in the question about where you see that going, how far you think that it can go and what is a sensible role for community pharmacy to provide a fuller and improved primary care service to our constituents and your patients.

[39] **Dr White:** May I make a comment, please? For years, we used to have local

pharmacists with whom we worked extremely well. I used to meet our local pharmacist weekly. We used to check through prescriptions, discuss things in general and he was invited to our Christmas party every year. He sold out to a multinational and now we only have in our area one local pharmacist with whom we work extremely well. The remainder are run by multinational companies that chop and change their pharmacists on a weekly and shift basis, and it is very difficult to generate any sort of rapport in that circumstance.

[40] **Dr Bailey:** To answer your more specific question—[*Inaudible.*]—the college and the Royal Pharmaceutical Society both have been talking. As a trade union, we talked with the pharmacists' trade union, the CPW, about two years ago, and we were both signed up to the idea that it would be helpful to try to introduce minor ailment schemes via the pharmacy contract. That did not happen, not because we were against it, but because it was not commissioned via the Government. Essentially, this is a commissioning issue, and we cannot simply decide to introduce a service, because the pharmacists would have no means of funding it. That is not to say that we were not supportive of the idea of a minor ailments scheme, and we continue to be supportive of the way that pharmacists and GPs work closely together, particularly in terms of substance abuse, where it is almost impossible to provide a primary care service without those two professions working very closely together.

[41] We would be happy to see an extension in some of the pharmacy work in supporting what GPs do in primary care, but that is not, with respect, a decision for the BMA. It is a decision for the Welsh Government.

[42] **Vaughan Gething:** In the evidence that you have given, you have spoken about the importance of patient records. Do you have a view on the developing practice in Scotland where some patient information is shared with pharmacies and there is, effectively, a registration process to allow that information to be shared on what appears to be a useful basis?

[43] **Dr Bailey:** Overall, inter-organisation sharing in Scotland does not come close to matching what we have in Wales. We share with out-of-hours services and with medical admissions units on a much wider basis than anywhere else in the United Kingdom. That is something that has been supported strongly by the Welsh Government, and it is fair to say that we are a long way ahead of the other three nations on that. It is more difficult to share data with pharmacists, because there are patient consent issues. Pharmacists maintain good records of their own with regard to what is prescribed, and outside of the big city, in most cases, a single pharmacy provides services for a single practice. That is certainly the case at my practice, where virtually all of my patients go to a single pharmacist—we have good communications, they have full records of what the patients take on a regular basis, because they have been dispensing to them, and they know that they can phone us at any time to share any information. It is more difficult than that, however, because while patients expect the doctor who looks after them in casualty or at the out-of-hours service to have some sort of access to the records—in fact, Wales is the only country in the United Kingdom so far where that is really the case; you cannot do that anywhere else to any significant extent—I am not sure that they yet expect the four or five pharmacists they may be able to choose from to have wider access to the records.

[44] That said, I do not think that we would have any problem with a spine, if you like, of what drugs patients are on being made available to pharmacists; that seems to me to be a sensible safety issue. There are issues even there, however, to do with confidentiality with regard to certain drugs that would identify clearly what people have. There would certainly need to be a lot of public consultation before we would be happy for pharmacists in general to have access to what we have now, which is the individual health record shared between clinicians, who see patients face to face and have to gain patient consent to see them for a clinical reason.

[45] **Dr Baker:** I should like to take that a bit further, in that I would like to see pharmacists and GPs working really closely together, preferably under the same roof, to provide clinical services. What prevents that is not the will of either profession, but the regulatory framework under which we work. It is as David said; that is the problem. It is not about willingness to work together; it is the regulatory framework that stops us from being able to do that. Sharing records is obviously the way to do it—shared clinical records and shared pharmacy records. Having them under the same roof is safe. It seems to me totally logical—it is a no-brainer, really.

[46] **Mark Drakeford:** I want to ensure that I bring other Members in. Kirsty, you wanted to ask something quickly, after which I am going to Lindsay and then Rebecca.

[47] **Kirsty Williams:** Taking Dr Baker's points on patient choice into consideration, I would be interested in exploring with you, Dr Bailey, where the limit is. You mentioned that smoking cessation, UTIs and emergency contraception definitely offer a role for community pharmacy. Clinically, where do you draw the line between what is safe to allow community pharmacy to prescribe and what needs to be seen by general practitioners?

[48] **Dr Bailey:** I think that the limit is where a degree of diagnostic uncertainty is involved. I am sure that Paul will have something to say about this as well. In a consultation about smoking cessation, I do not think that a pharmacist would need any more skills than he already has as a pharmacist, because there is nothing diagnostic involved in that. Emergency contraception is much the same, if you do it according to protocol. There are numerous other opportunities where such involvement could happen. What I would be concerned about is where the pharmacist would have to use diagnostic skills that he has not trained for. It is purely a professional issue. Where you can identify things for which you can provide a service through community pharmacy without the need for diagnostic skills, then I think that that is perfectly reasonable and it should come down to patient choice.

[49] **Mark Drakeford:** What about flu jabs?

[50] **Dr Bailey:** Flu jabs are not just about diagnostics, they are also about having a proper record. It is about being able to identify the right people. Until we have a full shared clinical record, it would be quite difficult to provide that service seamlessly. Our principal problem with having a pharmacist administer flu jabs is that you would not have a clear clinical record, and you are looking at a whole variety of at-risk groups—it is not just the over-65s, who are fairly easy to identify, but all the people in the clinical at-risk groups, carers, and pregnant women, who are also fairly easy to identify in the later stages. There are a number of people with regard to whom you have to be careful to have a continuous clinical record. At the moment, there is no real means to provide that seamlessly between general practitioners and pharmacists.

10.00 a.m.

[51] **Dr Myers:** The Royal College of General Practitioners is mainly concerned with quality, standards and the education of general medical practitioners. Looking at some aspects of the enhanced services in the pharmacy contract in which we would certainly have an interest, regarding minor illness, pharmacists go through four years of training and one year of pre-registration, therefore, they are highly experienced individuals. They are not specifically trained in advanced diagnostics, but they are trained in the management of minor illness. We would be happy to see them pick up some of that work and take it off GPs, who have more highly honed diagnostic skills. They also have an important role to play in encouraging patients to use over-the-counter treatments effectively. There might be a place for general practitioners to encourage people to see their pharmacist with regard to self-

management of minor illnesses. We would certainly support pharmacists picking that up.

[52] Quite a lot has been said about medicines use reviews, whereby pharmacists go through patients' medication with them. There is good evidence that, when medications fail, it is largely because patients are not taking them as prescribed. That is the biggest area—not prescribing or dispensing, but the way in which patients use medication. Sometimes, patients do not use medication appropriately because they have not had time to discuss with the pharmacist or the GP why they are taking that medication and what they hope to get out of it. Theoretically, therefore, there is huge value in medicines use reviews and in pharmacists looking through patients' medication and explaining to them why they are taking it and what they might expect. What is disappointing, looking through the research that has been published about medications use reviews, copies of which I believe were sent to you by Nuala Brennan, is that, while pharmacists think that the reviews are useful and patients who have had them think that they are probably useful, there is still an enormous number of patients who do not feel that it is appropriate to go to a pharmacist and who prefer to go to their GP for reassurance. Disappointingly, the feedback from GPs is that they, at the moment, do not feel that such reviews are particularly useful. That is probably because they are not necessarily targeted at the appropriate people. We are reassured, in the published amendments made to the contract over the last week, by the idea of targeting medicines use reviews at four or five particular areas. That will probably be of much greater value. Our concern has to be with efficiency. We are concerned that there may be duplication, certainly for people who are on only one or two medications, as they are usually seeing the general medical practitioner and having medication reviews, and adherence, when you are on only one or two medications, is usually pretty good. A pharmacist doing reviews for such people would not be appropriate, and it would mean possibly paying twice for the same service.

[53] Another area being looked at is travel advice. People going abroad, often at short notice, can get very good advice from pharmacists on how to manage simple conditions. It is not necessarily appropriate for them to give advice on the more complicated immunisations that might be required for more exotic destinations. Pharmacists should absolutely help us with health promotion and supporting public health messages about smoking, exercise, diet and weight, as more people will go into a pharmacy than into a GP's surgery. Around 80 per cent of the population go into GPs' surgeries, but probably more than that go into pharmacies. So help with health promotion would be very useful. I agree with David that, sometimes, the diagnosis of complex disease is, indeed, complex. That is something that GPs are skilled to do and pharmacists are not, so we would be anxious if they were to pick that up. With regard to point-of-care testing—doing blood tests—which is another proposed enhanced service, our concern would, again, be about duplication. Often, tests are requested for patients who do not need them. That is not a good use of public resources.

[54] Recent work has been done on cardiovascular risk assessments and pharmacists helping with that, and we support that. However, if they are going to be doing it, we want to ensure that it is done with us, and that there is collaboration and agreed protocols and systems so that we are targeting the right people. So there are a huge number of areas around enhanced services that we as a college feel that would be excellent for pharmacists to help us with, but we need good IT. We need to be able to communicate. Our IT systems are pretty good, but we are not yet linked into pharmacists' IT systems. There is important information that might be in a GP record that they cannot access, so we would like to see an improvement in that.

[55] **Mark Drakeford:** The noises off that you are hearing are usually heard when someone has inadvertently left a mobile device of one sort or another switched on—I say that in case anyone wants to check whether it is one of theirs. Given the time that we have left, we are going to have to move a little more swiftly through the remainder of the questions. I want to ensure that all Members have a chance to raise at least one or two points. Lindsay, I will

come to you next.

[56] **Lindsay Whittle:** Welcome. I would like to preface my remarks by saying that I think that pharmacies, with respect, are a little bit more than corner shops. I have found that your evidence is getting better as you go along. [*Laughter*.] I would like to ask you about the additional services provided by community pharmacists. Community Pharmacy Wales tells us that it can save us a great deal of money. I am talking about pharmacists talking to patients about chronic conditions, giving lifestyle advice—which you have mentioned—and about medicines waste reduction. We are constantly being told that there are far too many medicines going into bins, down toilets or just remaining on shelves. That is not acceptable. Do you have any thoughts on that, please?

[57] **Dr Bailey:** The new pharmacy contract for this year addresses that much more closely and would give much more support on that. It is about looking at discharges. Many discharges are of elderly people, who can be on 10 or a dozen drugs. As Paul said earlier, that is exactly the area where you need to be targeting medicines use reviews, because it gets very complex to follow those sorts of regimes. Many patients are coming home with regimes in dosette boxes, so you cannot actually see what they are taking. It becomes increasingly complex. They are also looking at medicines use reviews for people who are on more than a certain number of drugs. Those sort of things, which will be targeted—which will take a lot longer, but which would be a good use of public money—would be a sensible way forward. What is happening this year in the pharmacy contract seems to make much more sense than what has happened with previous contracts.

[58] **Lindsay Whittle:** I am very fortunate in that, if I ring my surgery in the morning, I will get an appointment that day. Many of my friends tell me that they have to wait a week or even two in some cases. If the ailment is not serious, they could go to the pharmacist and be prescribed some drugs that could cure them. I do not want to wait in the doctor's surgery with people who are giving me all sorts of infectious diseases, when I could get the medicine over the counter.

[59] **Dr Bailey:** The issue of whether you can be cured and what illness you have is part of the problem. You cannot cure a lot of viral infections, and that tends to make up a great deal of the acute work. In my practice, if you phone up, we guarantee that you will have a five-minute appointment the same day. I think that is a reasonable standard for us all to aspire to. I accept that that does not happen everywhere. However, the issue is still that you need some degree of diagnostic certainty. That is my one concern really. As Paul says, pharmacists are certainly trained to advise about minor illness. They can certainly advise you on symptom relief, and I think that it is entirely appropriate that they should do so. If we can have more continuity and consistency in that it would be extremely helpful. As Phil mentioned earlier, there is the issue that, although our local pharmacists are often fantastic and know the patient as well or better than the GPs, it is slightly different in the big multinational pharmacists, where you are very lucky to see the same pharmacist twice. So, there is a limitation to the continuity you can provide.

[60] **Rebecca Evans:** Could you say something about the cost savings offered by community pharmacies, in terms of financial costs to the NHS through prevention and so on and in terms of freeing up GPs' time so that they can spend their time working with patients who are probably in greater need or who have more complex needs?

[61] **Dr Bailey:** Again, I am sure that my colleagues will want to answer this question as well. Freeing up time is a very useful thing to do, clearly. If pharmacists can advise on minor illnesses, it will free up time for other patients with more complex needs. That is a very good use of pharmacy time. On the screening thing, again, you have to ensure that you are not paying twice for the same thing. Patients can already go along to their practice and get a

blood pressure check. Most of us will do a glucose check, or a cholesterol check, wherever it is appropriate, and not re-do it every five minutes if it is not necessary. You would probably have to commission that as an extra cost service from pharmacists, whereas currently you are getting it as part of the price, as it were. However, pharmacists looking at minor ailments is absolutely a way that you can free up GP services for more complex care, and make the health service more accessible for patients as well.

[62] **Dr Myers:** I am not an expert on financial savings, but I have a copy here of a pilot study that was done in the Aneurin Bevan Local Health Board looking at pharmacists' medicines use reviews and what now will be suggested in the revised contract. That pilot showed that, for those patients who were offered medicine use reviews, only for half did they lead to something different. So there was not a significant saving for the other half. However, for the other 50 per cent, the review often involves stopping a medication that is, perhaps, being prescribed but the patient has not told the GP that they are no longer taking it for whatever reason. So, there is pretty good evidence—I am sorry that I cannot give you figures—that, where pharmacists have looked closely at people who are on lots of different drugs and medications, often some medications can be stopped, some can be taken more appropriately and some can be changed to cheaper preparations. When a study was done in our area a few years ago, the savings certainly paid for the pharmacists' time, and there were savings in addition to that.

[63] It is difficult to prove it and to look at figures and show whether there is a saving and where that saving comes from. All of the evidence is a bit anecdotal. If you look at the overall outcome of medicine use reviews, and whether they have made a difference, there is no research that definitively shows that.

[64] **Rebecca Evans:** You might not be able to answer my next question, then. Do you have any examples of where community pharmacies have had a negative impact on either the NHS more widely or on patient care specifically?

[65] **Dr Bailey:** The only potential issue would be whether you are paying twice for the same service. I am not aware of any patient harm from pharmacists. I cannot see why that would ever happen.

[66] **Mark Drakeford:** Would you be able to share the paper that you were referring to with us?

[67] **Dr Myers:** Yes.

[68] **Mark Drakeford:** Thank you. That would be helpful.

[69] **Elin Jones:** I had hoped that what would have been presented to us this morning was that you see that there is an opportunity to free up GPs' time for the more complex diagnostic work that you have referred to by looking at the role that community pharmacies could play in providing enhanced services. As the evidence has gone on, we have got to a place where I think that what I am hearing is that some of the reservations that you may have about the execution of enhanced services by community pharmacies are surmountable with the right infrastructure, whether that is co-location, which you referred to, or information being shared in a formal way through patient records, or some other kind of information sharing.

[70] With regard to the flu jab, for example, we all know that the under 65s, especially, are not showing up for the flu jab in the numbers that all of us would like to see. Your reservation was that, if the flu jab was available in the community pharmacy, there would be no record of whether it had been provided in the GP's records, or of who was turning up for the jab; anyone could turn up and say that they are in the at-risk category. However, it seems to me

that systems could be put in place to ensure that it was not abused in any way. So, would I be right in summarising that you have, in principle, no objection to enhanced services being undertaken by community pharmacies provided that the reservations with regard to shared information are addressed?

[71] **Dr Bailey:** I have absolutely no problem with using enhanced services to improve the services from community pharmacies. None at all. There are reservations, clearly, but if they can be overcome, we would commend that mechanism of delivering services, because that is exactly how GMS has delivered services. So, we would be supportive of that.

10.15 a.m.

[72] **Mark Drakeford:** Lynne, did you have something that you wanted to ask? I see that it has been covered already. Dr White, we are only just hearing you, please go ahead.

[73] **Dr White:** The fire alarm has gone off, and Ysbyty Gwynedd is still here, you will be disappointed to hear. The biggest problem with pharmacists dealing with minor illnesses is that they cannot issue free medication. It is all right for those of us who have a few bob and can afford £4 for a bottle of Calpol for our child, but it is difficult for those people who are short of money. One thing that we have not highlighted as far as rural health is concerned is rural poverty, which is far more difficult to define than inner-city poverty. Perhaps one thing that you need to do is look at a mechanism or vehicle whereby pharmacists might be able to issue free medication, as they do with free contraception. Until you do that, you will find that the uptake of pharmacy advice will be quite low, especially in rural or poorer areas. Those are probably the areas in which the GP is under the most stress, so that needs addressing.

[74] **Mark Drakeford:** An interesting point; I do not think that we have heard otherwise. Do you want to add to it?

[75] **Dr Myers:** The opposite argument is that, in rural areas, dispensing doctors cannot sell cheap items to their patients. In Wales, it does not matter, because you do not have a prescription charge, but, over the border, it matters hugely. It is a question of access. May I go back to something that Elin said? The team approach is what matters. If you get a team approach to patient care, it will work. Separation and what is almost union bashing do not work.

[76] **Mark Drakeford:** I am looking around to see whether anyone wants to pose a final follow-up question on the evidence that we have heard this morning. I see that no-one does. David, do you want to sum up anything that we have not touched on that you are keen for us to take away from this morning's session, or are there any points that you want to return to?

[77] **Dr Bailey:** We have had a useful and wide-ranging discussion and we have covered most of the points that you wanted to cover and some of the points that we wanted to be sure that you were aware of, even if they were not strictly in the consultation. This has been a useful discussion.

[78] **Mark Drakeford:** Thank you.

[79] Diolch yn fawr i chi i gyd am ddod. Thank you all for your attendance.

[80] You will get a transcript of today's proceedings, as you know, and if there are any things in there that have been factually incorrectly transcribed, we will be glad to have them pointed out to us. Thank you all for joining us, especially Dr White; I am glad to hear that Ysbyty Gwynedd remains in place. We will now have a short break.

Gohiriwyd y cyfarfod rhwng 10.18 a.m. a 10.29 a.m.
The meeting adjourned between 10.18 a.m. and 10.29 a.m

Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Inquiry into Stroke Risk Reduction—Evidence from the Minister for Health and Social Services

[81] **Mark Drakeford:** Bore da. Croeso unwaith eto i Lesley Griffiths, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol. Yr ydym yn holi'r Gweinidog y bore yma am y dystiolaeth yr ydym wedi'i derbyn yn yr ymchwiliad i leihau'r risg o strôc. Croeso i chi ac i Dr Tony Jewell, Prif Swyddog Meddygol Cymru, a hefyd i Dr Chris Jones, cyfarwyddwr meddygol GIG Cymru. Bore da a chroeso i chi gyd.

Mark Drakeford: Good morning. Welcome once again to Lesley Griffiths, the Minister for Health and Social Services. This morning we are questioning the Minister about the evidence that we have received in the inquiry into stroke risk reductions. Welcome to you and to Dr Tony Jewell, the Chief Medical Officer for Wales, and also to Dr Chris Jones, medical director for NHS Wales. Good morning and welcome to you all.

10.30 a.m.

[82] I am grateful to you for finding time to help us with our inquiry into reducing the risk of stroke here in Wales. We have already had a number of sessions in the relatively brief inquiry that we are conducting into this matter. We are interested not in stroke services in general, as you know, but in a rather narrower slice of services that are designed to help reduce the risk of stroke, and we have heard evidence from a variety of interest groups. We are going to lead off with a question from Lynne.

[83] **Lynne Neagle:** Thank you, Mark. I wanted to pick up on the issue of transient ischaemic attacks. We heard compelling evidence last time that a TIA is a very powerful indicator of people who are going to go on to have strokes, but we also heard, very worryingly, that a lot of people in Wales do not get access to the surgery that they need within the 48 hours that is recommended by the royal college. Can you say a bit more about how patchy you think provision is and how many people are getting access to surgery within the appropriate timescales? Also, very importantly, what do you plan to do to ensure that everyone who has a TIA has the surgery that they need within 48 hours?

[84] **Lesley Griffiths:** Thank you, Lynne. You are absolutely right; TIAs are a very strong indicator that, unfortunately, a bigger stroke could be on its way. So, we need to ensure that people have access to the right services to prevent that happening. On how patchy it is, one of the reasons that we are having a national stroke delivery plan is to bring all these things together to ensure that we have the service. Yesterday's announcement on 'Together for Health' is another reason why we need to ensure that we have the specialist centre so that people, if they need thrombolysis within four hours, or if they have had a TIA and they need a different treatment, are able to have that. I will bring Dr Jones in on that as well.

[85] **Dr Jones:** I absolutely agree that TIAs are a very powerful indicator of a high risk of stroke. Patients need to be seen very quickly; we need TIA clinics operating seven days a week in all areas for patients with high-risk TIAs and, as you say, they need to have very early access to carotid investigation and carotid surgery, where appropriate. We know that, in the past, we have not provided that level of service; we know that from our own assessments and from the national clinical audit for carotid endarterectomy, which is run by the Healthcare Quality Improvement Partnership. To address this, we have TIA services subject to an intelligent target, which is part of the 1000 Lives campaign, which supports service

improvement, and our colleagues in the delivery and support unit—the lead executive director there being Richard Bowen—are taking on TIA services. I can now report that all areas are offering TIA clinics for high-risk patients five days a week, delivering an assessment the next day. They are not all there with seven-day clinics, but some are, and there is rapid improvement in the provision of TIA services.

[86] We still have some way to go with carotid endarterectomy. Timing is crucial, but we have asked Anne Freeman, who is our lead clinician for stroke, to include that in her brief to improve our performance in the national clinical audit. We also anticipate that the national clinical audit will be a tier 1 measure, on which organisations will be held to account next year, so this will be a very important issue for the health boards in the future.

[87] **Lynne Neagle:** Based on the measures that you are bringing in, when do you expect people in Wales to have access to that surgery within the 48 hours on a uniform basis?

[88] **Dr Jones:** I would expect that, by next April, we will have excellent TIA services and we should perform well in international comparison terms in the national clinical audit for carotid endarterectomy.

[89] **William Graham:** Minister, I want to ask about the services mapping exercise and the recommendations that have clearly been received. When do you hope to issue a response on that?

[90] **Lesley Griffiths:** The mapping exercise—sorry, what did you mean?

[91] **William Graham:** The mapping exercise. You have had the recommendations, I gather. When are you likely to issue a response on that?

[92] **Lesley Griffiths:** Do you know what action point that was, William?

[93] **William Graham:** The one that notes:

[94] 'The Welsh Government tasked Public Health Wales with mapping existing services across Wales which assess people at risk of cardiovascular disease.'

[95] **Lesley Griffiths:** Sorry, yes; it is the end of this year—the end of December.

[96] **William Graham:** Have you had the recommendations yet?

[97] **Dr Jewell:** It submitted a report to us this summer, and we have asked it to come back with specific recommendations by Christmas; so, we are expecting its final report next month.

[98] **William Graham:** When will you issue your response?

[99] **Lesley Griffiths:** It will be early in the new year.

[100] **Dr Jewell:** Yes. We will have it by Christmas. It produced quite a detailed initial report, on which we consulted. We have asked it to come back with more specific recommendations by Christmas.

[101] **William Graham:** How is data effectively collected and utilised? How can they be used to direct resources to best effect?

[102] **Lesley Griffiths:** Most of the collected data fit into the quality and outcomes

framework that are to do with the General Medical Council contracts. GPs are required to keep a register of patients who have had a stroke. As part of the ongoing management of stroke, GPs record the percentage of patients with a history of stroke. So, for instance, anyone who has a high blood pressure reading, people with a measured cholesterol level of more than 5 and people who have had influenza are included on that register. The data on those lifestyle risk factors are then collected by the Welsh health survey, and they are taken into consideration when we plan health improvement programmes, especially local programmes.

[103] **William Graham:** Would that dictate priorities in certain areas?

[104] **Lesley Griffiths:** Yes, it could do.

[105] **Rebecca Evans:** Throughout the evidence that we have received, the theme of a lack of ownership of this stroke risk reduction plan has come through strongly. As Minister, how have you been ensuring an integrated and co-ordinated approach to the delivery of that action plan between primary care, secondary care and public health?

[106] **Lesley Griffiths:** I am responsible for the stroke risk reduction plan. You will be aware of some of the action points that I mentioned in my letter to the Chair; some have started, some are completed, some have not been started and some have been superseded. One of our manifesto commitments was delivery plans for chronic conditions, so we are in the process of drafting the national stroke delivery plan. The current reduction plan will finish in the spring, and the national stroke delivery plan will then take over.

[107] I am sure that Dr Jones can say more about the integration between primary and secondary care.

[108] **Dr Jones:** I have not been personally involved with the risk reduction plan up to now, but I am involved in the development of the delivery plan. It is about laying out our expectations on organisations and what we will measure and hold them to account on. The idea is that these delivery plans are not necessarily new initiatives, but that they integrate all the current policy and strategy standards into one delivery expectations summary. They will all follow themes that are mapped back on the themes of 'Together for Health', which was announced yesterday. We will expect organisation to work together as integrated organisations, across primary, secondary and tertiary care, to deliver better outcomes.

[109] **Lesley Griffiths:** In the annual quality framework for this year, we have introduced the requirements for each local health board to produce a public health strategic framework that will focus action on primary prevention.

[110] **Rebecca Evans:** With regard to laying out your expectations, how do you see the role of local authorities and social services, especially in stroke risk reduction, and how are you communicating those expectations to them?

[111] **Lesley Griffiths:** Local authorities and social services, clearly, have a vital role to play with regard to stroke prevention and intervention. Local authorities, in particular, have a strong contribution to make, particularly with reference to their health, social care and wellbeing strategies. The development of the stroke risk reduction action plan took account of a series of national discussions that had taken place, and questionnaires at local health board and local authority level, through the local public health teams and the health, social welfare and wellbeing co-ordinators. The guidance that I have given for the development of those strategies requires local authorities to address the 10 priorities of 'Our Healthy Future'—that is the main policy, and it has to include reference to plans such as the stroke risk reduction plan.

[112] **Mark Drakeford:** Lynne, you wanted to come in on this point.

[113] **Lynne Neagle:** It was just on the interface between primary and secondary care. When we had Aneurin Bevan Local Health Board representatives here, we were told that it had a GP on its steering group that drove this forward in Gwent. However, that clearly was not the case in other parts of Wales, and the GPs who were here thought that it would be good if that were to happen. Are there any plans to put in place a consistent approach? GPs are clearly fundamental, and need to be right at the centre of this, do they not?

[114] **Dr Jewell:** If I can add to that, the way that we look at this is that the determinants of stroke risk are things like obesity, a lack of physical activity, tobacco, salt in diet and so on. There is a whole box there that, essentially, fits into the population public health strategy, 'Our Healthy Future' and 'Fairer health outcomes for all'. There is another box here that is about risk factors such as blood pressure, atrial fibrillation, obesity and so on, which fits clearly into the primary care set-up, including the quality and outcomes framework measures, or QOF measures, which you would have heard about. The third box is if someone has had a stroke or a transient ischaemic attack, and then that fits into the care bundles, the intelligent targets and the delivery, particularly in the hospital sector, that we have been pushing.

[115] Your initial question was on how these things are related; it is complex, because many of these determinants or risk factors are very prevalent in the population, then there are those factors that are dealt with in primary care, and then there is stroke, which is much rarer, but which is mainly dealt with in the hospital setting. We need to have an overview of all of those, so that is what you find in the health, social care and wellbeing strategies locally, and that is what you find in 'Our Healthy Future' and the national service frameworks nationally. What we need to do in looking at the data is see how box 1, box 2 and box 3 are being delivered across Wales. There is not just one individual or organisation that would have exclusive oversight of this.

[116] **Mark Drakeford:** Kirsty, I will go to you next on this point, and on anything else that you want to ask on this, and then I will go to Elin.

[117] **Kirsty Williams:** In paragraph 18 of your paper, you talk about the National Institute for Health and Clinical Excellence guidance on hypertension, and we have received evidence during this review that, although there is an understanding and knowledge of that guidance, it does not result in changes in practice, especially with regard to the prescribing of anticoagulants—that is, the number of patients who are in receipt of anticoagulants, and who are then properly monitored to ensure that the drugs are being prescribed at the right level to make them effective. What are you doing with general practices to ensure that patients who need anticoagulants are actually prescribed them, and are adequately monitored? We have heard that one of the reasons this does not happen is the inadequacy of the QOF that Dr Jewell just mentioned. We have received evidence that the QOF needs to be changed to place greater emphasis on this work to ensure that GPs actually do it. I am just wondering what you are doing with GPs to ensure that the right people are on the right medication at the right time.

[118] **Lesley Griffiths:** The percentage of patients with atrial fibrillation who are treated with anticoagulation drug therapy or antiplatelet therapy was 94 per cent last year. Obviously, it is something that a lot of patients are on. Sometimes, certain treatments are contra-indicated, and sometimes patients decline to have anticoagulation treatment. It is up to the doctor to decide the most appropriate treatment for that patient. Obviously, the local health boards are responsible for the quality assurance of GP services, including the use of guidance, so I suppose the main thing that I am doing is requiring local health boards to produce an annual primary care report to ensure that such processes receive appropriate scrutiny through the local health board.

10.45 a.m.

[119] **Kirsty Williams:** So, you would disagree with the evidence that we have received in committee from patient groups and GPs that the QOF needs to change.

[120] **Lesley Griffiths:** I suppose that that is something that we could look at. I am not aware of any reluctance on the part of GPs to prescribe the treatment, because the figures that I have show a patient uptake of 94 per cent.

[121] **Dr Jones:** The QOF provides points for keeping a register of AF patients, and for having a conversation and making a decision about what drug treatments these patients should follow; 94 per cent of patients have that conversation, and the overall compliance with the AF QOF points in Wales is 99 per cent. However, there is some uncertainty within that about whether the right decision is made in every individual case, and whether some people who should have warfarin are left on aspirin. That is quite difficult, because the QOF cannot prescribe what the clinical decision should be in an individual case. If you set too high a standard, it becomes a disincentive and no-one engages. So, there is developmental work to be done.

[122] It is partly about the quality assurance of the QOF measures, but there is also separate work to be done. In fact, we are kicking off that work, but it is at a relatively early stage, through the 1000 Lives Plus programme. That programme has until now been focused to some extent on harm related to hospital care, so we have known for a while that we need to extend it to primary care. AF and anticoagulation are one of the principal areas on which we will focus. That work has started. We have asked each health board to identify some keen practices that are willing to engage with us. It has produced a driver diagram and a toolkit about how to make these decisions, what scoring systems they should be using and how they should make these clinical decisions. We would like that to be rolled out, but in the rather heterogeneous environment of independent practitioners, it depends on their participation and collaboration. The 1000 Lives Plus programme methodology, which is about local improvement, is potentially quite powerful, because it is a bottom-up approach and it engages people. So, we hope that that will be a way of bringing things on. There is probably significant room for improvement in the delivery of anticoagulation where it should be delivered.

[123] **Mark Drakeford:** That is indeed the evidence that we have had, namely that the 94 per cent figure, by itself, may be disguising the optimum use of anticoagulants, and that it could include aspirin as well as warfarin, and aspirin may not always be the right course of treatment. We have also heard that there are tools now available that might be more effectively used at a general practice level to makes sure that the right sort of anticoagulant is used. So, it is interesting to hear you confirm that.

[124] **Elin Jones:** On atrial fibrillation again, we have had quite a bit of evidence on the lack of awareness regarding risk factors for atrial fibrillation. I would say that there was quite a significant lack of awareness among the general public of atrial fibrillation and risk factors, but there also seems to be such a lack among health professionals. What should GP practices be doing to proactively pursue the diagnosis of atrial fibrillation among their patients? Do you agree that there is a lack of awareness among the general public, and what do you think the role of LHBs and GP practices should be to improve the diagnosis of atrial fibrillation?

[125] **Lesley Griffiths:** Atrial fibrillation sometimes does not have any symptoms, so the statement that I made that I wanted every health intervention to be a public health intervention supports this. We had the Ask First campaign where we wanted people to ask to have their pulse checked, because that is one way of finding out if someone has atrial fibrillation, and there have also been other such public health campaigns. We need to raise awareness of the

risk factors of stroke among the public, and a great deal of work has already been done on this. We have also had the Face Arms Speech Time campaign. It is about making sure that people are aware of the risks and are making the right lifestyle choices, namely reducing smoking, alcohol misuse and increasing physical activity. Again, the over-50s check that we are bringing in will help to raise awareness among people.

[126] **Elin Jones:** There is something very specific with atrial fibrillation and checking pulses—you have referred to that already. What more do you think that the Government, local health boards and GP practices could do to raise the general public's awareness of the role that pulse checks can play, whether they are done at home or formally in a GP practice if a patient asks for one?

[127] **Dr Jewell:** There are two things here. The first is to do with the public. As the Minister says, we supported the Stroke Association in its Ask First campaign. I personally visited a couple of its road shows. The association was essentially working with employer organisations to try to get at the working-age population because you need to identify this risk in mid to later middle age. So, occupational schemes in the workplace were one of the focuses of its campaign. That was aimed at the general public, particularly the working-age population.

[128] The second thing is about how far primary care is doing it. We have already had a discussion about the QOF, and it was ascertained that atrial fibrillation in primary care is part of it. So, the expectation would be that GPs and primary care teams are aware of the risks of atrial fibrillation and assess it as part of a risk profile that includes atrial fibrillation, family history, and other risk factors. So, that is the primary care setting. We see it as a combination of working on public campaigns—Ask First was an example, but we may need to do more—as well as ensuring that primary care, as was referred to in early conversations, is doing it systematically as part of vascular risk assessment, which we are trying to integrate into our health checks

[129] **Elin Jones:** Is the QOF specific enough in terms of proactive diagnosis, such the checking of pulses for atrial fibrillation?

[130] **Dr Jewell:** Probably not, but it is difficult to know how to quantify that. I think that I agree with you that the public is relatively unaware of AF, given its prevalence—it is an epidemic, really. As the population ages, the prevalence of the condition increases massively, but it is very difficult to know how many cases of atrial fibrillation are going undiagnosed. We could look at international comparisons for the prevalence rates, but I am not aware of any work that has done that.

[131] You could argue that if there are no symptoms attributable to atrial fibrillation, the only point in diagnosing it is the stroke risk. In the absence of other chronic diseases, it is age-related. Most of these people will be going to the GP for different reasons anyway once they are in their late 70s or 80s. The GP should then, as a matter of good practice, take their pulse. One would hope that that is happening and I do not have evidence that it is not. So, it is a difficult one. It is a rather difficult one to answer quantitatively. There is no evidence, as far as I understand, from the work that has been done to indicate that it should be subject to a screening approach. I do not think that that would be right.

[132] **Mark Drakeford:** Lindsay and Lynne want to come in on this specific point, and then Vaughan has a question, so we will do a little round on this.

[133] **Lindsay Whittle:** I had high blood pressure, although it is now controlled. Incidentally, it was identified by a nurse, not a GP. Until I became a Member of the Assembly, I had never heard of atrial fibrillation, but, again, I was informed about it by a

nurse. So, that is one up for the nurses, I would suggest.

[134] I am concerned about how we reach our target audience in the campaign. How is it monitored and evaluated? I was in a rugby club not so long ago and I met a young man who had suffered a stroke, and he would never have thought that he would suffer a stroke. While it is tragic for anyone to have a stroke, it somehow seems more tragic for those people, and we should be identifying them.

[135] **Lesley Griffiths:** The need to raise awareness among the population is a key element of Welsh Government activity. We have just mentioned the campaigns that we had. Obviously, the programme for government gives a clear commitment to deliver an annual campaign to help to address our public health priorities. That will raise awareness of the potential longer term impacts of sustained unhealthy behaviours and encourage behavioural change. We need to look at the campaigns that we have referred to, particularly the Ask First campaign, and evaluate them to see what we can learn from them, where we went wrong, and what we need to do better. However, I think that the Ask First campaign was effective in raising awareness among people. It was often done in the workplace, which is a good place to have these campaigns. We must not underestimate the amount of work that we have to do with the public to raise awareness about this.

[136] **Lindsay Whittle:** We target GP surgeries, bus shelters and other places where there are public noticeboards. Should we be targeting takeaway shops, working men's clubs and rugby clubs? I am not suggesting that all takeaway food is bad for you, but, I do not think that it is the best eating habit in Wales.

[137] **Lesley Griffiths:** You are correct; we need to look at different places. For instance, we had a seasonal flu campaign on buses in rural areas. That is also an important way of doing it. We need to look at what lessons we can learn from the Ask First campaign in particular.

[138] **Mark Drakeford:** Kirsty is wondering where these buses in rural areas are.

[139] **Kirsty Williams:** You did not have to spend much money on those posters. [*Laughter.*]

[140] **Lynne Neagle:** Following Elin's question, I am still not clear why some GPs are screening and some are not. Dr Jones said that some are doing it as good practice. Is it as simple as that? Are these particularly conscientious and thorough GPs, or is there something in the guidance that encourages those GPs to do it? If so, should we not be strengthening that guidance so that all GPs do it where it is indicated?

[141] **Dr Jones:** It is a matter of good clinical practice. I do not think that there is any guidance out there from the Welsh Government that says that you must take the pulse of everybody who comes to see you. I do not know if we are missing a large number of patients with atrial fibrillation.

[142] **Vaughan Gething:** Picking up on screening and public health issues, a lot of the evidence that we have had suggests that there is real scope for systemic opportunistic screening—which sounds like a bit of a misnomer—when people come in who should be, or are likely to be, in high-risk groups. The screening should be done then. Nobody is suggesting that we have a national screening programme, even though that would be effective. I am surprised because I expected there to be a clearer view about whether opportunistic screening should be something that is rolled out and encouraged on a more consistent basis, and whether that would form a part of the national stroke plan. If not, how are we going to get there? Otherwise, it appears that we will just have to live with this inconsistent practice, and

that cannot be a sensible place to be.

[143] **Dr Jones:** The difficulty is in starting with evidence-based policy. I would expect GPs to take the pulse of elderly people who come to see them, because they can then diagnose atrial fibrillation if it exists. I do not know whether there is justification for a policy where that is required. I am not sure how that could be done. There are educational issues that we can address by raising awareness. I am not sure that there is evidence that that is necessary among the GP community. People are aware that atrial fibrillation is an important risk factor for stroke. So, it is a question of how to respond on the basis of evidence.

[144] **Vaughan Gething:** We have plenty of evidence about an ageing population—people are living longer and are, therefore, older for much longer.

[145] **Dr Jewell:** As Chris Jones has just said, we look at evidence-based policy, and we are part of the UK National Screening Committee, which advises us on screening programmes. Currently, it does not recommend screening for atrial fibrillation. It has looked at it and will look at it again, and it expects to report next March. Evidence can shift, but, at present, it does not recommend screening. You said that it does not necessarily have to be systematic screening, but, that is the formal position. You mentioned opportunistic screening. One of the things that we are working on at the moment is the Government proposal for health checks, including vascular risk. This is an example of vascular risk and we have received evidence from Public Health Wales about vascular risk. We are currently looking at that with regard to the Government recommendations about health checks for the over-50s. I reassure the committee that it is actively being looked at by the national screening committee at a UK level in terms of best evidence. In addition, in Wales, we are looking at the opportunity for health checks for the over-50s, of which vascular risk—of a brain attack or stroke as well as a heart attack—would be a key part. I can reassure the committee that all options are being actively looked at, from systematic screening programmes to the quality and outcomes framework and health checks in order to get the best evidence.

11.00 a.m.

[146] **Vaughan Gething:** No-one is saying that you should not run a public health campaign, but I am interested in how success is measured, what the expectations are at the start as to what it wants to achieve, how many people it wants to reach and whether those at-need and at-risk groups are properly targeting. How effective are campaigns on specific health risks such as stroke, heart disease and other risks, or is there greater purchase and gain from wider public health messages about healthy lifestyle and eating, for example? I am not sure where the evidence is for each of the campaigns that are conceived, how they are run and how you measure that success. I know that you said that this was a fairly well-run and successful campaign, but I do not understand what the benchmark for success is in that sort of campaign.

[147] **Lesley Griffiths:** We have seen a sharp reduction in the number of stroke deaths over the past four or five years. I visited a stroke unit in the Hywel Dda Local Health Board area over recess. People there were telling me that although the number had dropped significantly, a cause of concern for them—and this is something that I have spoken about to Dr Jewell, particularly in relation to public health—is that the age of people suffering a stroke has lowered, so we need to look at campaigns to address that. That is something that we are evaluating. I do not know whether Dr Jewell wants to add anything about the evaluation of campaigns.

[148] **Dr Jewell:** As you know, health-related behaviours—whether they are about obesity, physical activity, smoking, alcohol—is a complex issue. One of the things that we have used is the so-called four Es approach, which understands that some of it is about exemplifying and

some of it is about enabling people to have healthy lifestyles, and so on. Take smoking, for example. The Minister is looking at the results of the consultation on the tobacco control action plan, which will be issued by the end of the year. The plan contains the idea that there should be a target related to the percentage of the adult population that smokes, moving it from 23 per cent to 16 per cent by 2020. That would be an example where Government sets a target and then has a variety of mechanisms to try to get to that target. However, this will not be only one specific media campaign; it will be a combination of the four Es. It can include legislation, for example, banning cigarette vending machines, but it could also include taking measures within the NHS—by banning smoking in the grounds of hospitals, for example—as well as a variety of mechanisms to try to get to that 16 per cent and track our progress towards it. It is complicated, because people's behaviour is complicated.

[149] Take the four risk factors of smoking, alcohol, unhealthy diets and physical activity. It is estimated that less than 3 per cent of the population adhere to advice on those four risk factors. Those factors determine many things—diabetes, heart disease, stroke and so on. So, if we ask people whether they adhere to sensible drinking, have a healthy diet, undertake physical activity to the recommended level, and whether they smoke, very few people can tick all four boxes. It is very complicated, but it is not to say that we should not have targets. I have given tobacco as one example, but the mechanism to get there will have to be a combination of legislation, enabling people to cycle and walk and so on, as well as individual counselling on smoking cessation.

[150] **Lesley Griffiths:** My reaction to that figure was the same as Vaughan's when Dr Jewell asked me what that percentage was. I said that it would be in single figures, but I thought that it would have been higher than 3 per cent. It is a huge challenge to get people to change their lifestyles, and the best thing that we can do as a Government is to make sure that people have all the information they need to make the calculations of how they look after themselves and promote healthy lifestyles.

[151] **Mark Drakeford:** Gwyn, did you have a point on this area?

[152] **Gwyn R. Price:** Yes. With all that in mind, it is a bit frightening, especially for me. Is there a date for introducing the over-50s health check?

[153] **Lesley Griffiths:** No, it is something that we are looking at. I have asked officials to do a scoping paper early in the new year, looking at the evidence that is around to see how we can take that forward. So, we are a little way off introducing the checks, but, hopefully in the new year, we will have some firm evidence to go on.

[154] **Gwyn R. Price:** I think that it is in the public domain that the over-50s health check is a part of a commitment. My constituents ask me on a regular basis when it is going to start. I am a little bit disappointed that the answer is that we do not know.

[155] **Lesley Griffiths:** It will not be before the beginning of 2013. However, we are doing a lot of preparatory work at the moment. It is a five-year programme for government. We cannot do everything before Christmas. There is a lot of preparatory work to be done.

[156] **Kirsty Williams:** While you are doing this preparatory work to establish this scheme, I suppose the danger is that the people who will turn up for their over-50s health check are precisely those who are in that 3 per cent, who do not drink too much, who eat the right food and do the right exercise, because they are engaged in looking after their health. The people who are not likely to go to their doctor's surgery are those people who have all those risk factors. How can you develop a programme that gets to the people who need that check the most, because they are the least likely people to engage and to take the time to be checked? How do you overcome that dilemma? Otherwise, you are going to be treating the worried

well, and GPs are going to be spending their time talking to people and checking people who are already engaged in that agenda.

[157] **Lesley Griffiths:** I suppose it goes back to what I said before about every health intervention being a public health intervention. We want the GP to check the pulse, for example, of anyone who goes to the doctor, and if someone went along to a pharmacy they could have information about that. Lindsay mentioned that he had his public health intervention from a nurse. There are lots of ways of doing it already. We have to make sure that we get it right. There is a lot of preparatory work to do. We have started reviewing the evidence base. Kirsty, you have raised the issue of the age with me in this committee and in the Chamber. So, again, we need to ensure that we have that right. It will be introduced; it is a Government commitment. However, we need to focus on the preparatory work that is taking place at the moment.

[158] **Kirsty Williams:** It is slightly curious to me that you promise the Welsh public that you are going to do something, and then you scrabble around and find the evidence to justify that that is what the right policy intervention is. It seems to me as a slightly back-to-front way of doing it. A commitment to improve public health by introducing age-appropriate screening might have been a more subtle, albeit slightly less catchy, way of making a promise.

[159] **Mark Drakeford:** We will take that as an observation. We will move on, because we are giving this particular issue a substantial run around. I will ask the last question on this topic for now. Your mantra of every health encounter being a public health encounter is a powerful one. However, one of the things that has been put to us about opportunistic screening for atrial fibrillation is that because a lot of different health professionals could do it, we are never quite sure who is doing it. Nurses could do it. We were told that community pharmacists could do it. This morning we rehearsed the way that GPs can do it. Dr Jewell raised the issue about the systematic approach to this. Is there a view from inside the Welsh Government as to how we could have a systematic approach to opportunistic screening for AF that allows us, in a co-ordinated way, to use all those different encounters that go on already and turn them into an opportunity to check for AF?

[160] **Dr Jewell:** I will have a go at answering that. In a sense, it comes back to the previous question about the inverse care law, which states that those in greatest need generally receive poorer quality care or do not access treatment. In Wales, we have an opportunity through our developing electronic health records, and the fact that they can talk to each other, to address those questions of who did not come for a check and who needs to have their blood pressure or their pulse checked versus measurements done in pharmacies or hospitals, with all those being pulled together in one individual record. Part of the work we are doing on health checks is to establish the extent to which we can engage the public, through MyHealth Online in the same interactive way, with what the health service knows about their risks and what they should do about it. I know that there will be the engaged public.

[161] However, part of the idea that we are talking to the Minister about is using Digital Wales and the electronic environment we are moving towards to try to ensure that the GP record, for the sake of argument, is the place that holds the ring. Even if the community pharmacy does a measurement, we must ensure that the data get back to the core medical record and that, ultimately, MyHealth Online accesses some of that information as well to engage the public. In so doing, through primary care systems, you can work out who has and has not had some of these opportunistic tests, depending on people's age and risk profiles in order to get a systematic approach to this. That is the way that we will be thinking in NHS Wales in the future.

[162] That is balanced by the health surveys that are undertaken, such as the Welsh health

survey. For example, through QOF, practices report that around 15 per cent of people are treated for raised blood pressure in Wales. The Welsh health survey would report that it is 20 per cent. That is an issue for us to look at, but it does not mean that we should not do the Welsh health survey. There are ways of trying to bring those data together, which I think would be a function of Government.

[163] **Dr Jones:** I just want to comment that I still think it is largely an educational issue, because it is a matter of good clinical practice. However, I take the point entirely that it could be any member of the clinical team, the primary care team or the community resource team that does this. We have some influence over the educational component of CPD programmes for GPs. We have a close relationship with the directors of public health in each of the health boards. They can influence these things. They determine, I think with clinical colleagues, the programme for CPD. So, I think that that is the best approach. The other way to influence primary-care behaviour is by paying for it through some kind of direct enhanced service. However, I do not think that there is a sufficient evidence base to say that that should be a priority.

[164] **Mark Drakeford:** Thank you very much. I think that we have had a good run around the issues of screening, who should do it and so on. We have about 15 minutes left with you, Minister, so I am going to move us on to fresh issues. I know that Rebecca has a question. Then I will go to Elin and Vaughan. If the issue has already been covered, we will move on to someone else, but that is the order I have for the moment.

[165] **Rebecca Evans:** I would like to move on to the issue of telemedicine, because we have not touched on it yet. Can you update us on the current use of telemedicine so far as stroke reduction is concerned? How realistic is it that telemedicine and schemes such as MyHealth Online will fulfil their potential, given the broadband challenges that still exist in parts of Wales?

[166] **Lesley Griffiths:** I think that I mentioned yesterday in the Chamber that the NHS Wales Informatics Service has a huge role to play, and, obviously, telemedicine fits into that. Consider a situation where a decision has to be taken within four hours where, for example, a patient requires thrombolysis because they are having a bleed or have a clot. Telemedicine has a huge role to play, particularly in rural areas. The news last night, in the package about yesterday's announcement, showed a telemedicine conference taking place. Telemedicine has a huge role to play. Obviously, broadband issues are significant because there are areas of Wales that are not covered by broadband. I know that officials have meetings with the Department for Business, Enterprise, Technology and Science to ensure that we get better broadband coverage. However, telemedicine has a huge role to play. It is well used in relation to stroke services and that will go further.

11.15 a.m.

[167] **Vaughan Gething:** I have a specific point about the stroke risk reduction—[*Inaudible.*] I am interested in how that will take account of health inequalities and targeting. To what extent are health inequalities taken into account in how you want to see the plan implemented? If they are, how do you expect those to be identified in the plan and then measured so that it is not a case of saying, 'We wanted this to be done, but we are not sure whether it has been'? Again, who takes ownership of that? If you give the direction, who delivers that and how do you hold them to account for ensuring that it is done?

[168] **Lesley Griffiths:** I think that it is probably Dr Jones's department that is having discussions with Communities First areas about health inequalities and stroke—

[169] **Dr Jones:** It is not my department, actually.

[170] **Lesley Griffiths:** It is not, sorry. I know that there are discussions going on with Communities First areas, where we can look at health inequalities. That will be fitted into the national stroke delivery plan. The plan is intended to set out the results that I want to achieve in tackling stroke across Wales. It will direct and guide the actions that I think that the NHS in Wales needs to take. So, it will be dispersed to the LHBs and someone will take ownership of taking that forward. It will bring together all the key elements in relation to stroke and it will be clear about the outcomes that I want to see across Wales.

[171] **Vaughan Gething:** Is that confirmation that health inequalities will not feature as part of the plan, but that there will be a clear understanding of what health inequalities you want to address through this plan and of who will be responsible for delivering those, so that, if we look at this again in a year's time, you can say, 'Here's the plan, here's what I wanted to be able to do, here's how I've measured what they've done, and here's how I've addressed issues where I feel that either there is good practice to share or people haven't done what they needed to do, and here are the measures I've taken'? Will that all be part of what you will produce?

[172] **Lesley Griffiths:** Yes, it is being looked at at the moment. The plan that we have at the moment is not an all-inclusive plan; it was never intended to be. It was always going to be developed as part of the stroke services improvement programme workstream. I will pass over to Dr Jewell for him to pick up on the specific point that you raised.

[173] **Dr Jewell:** To return to my earlier point about box 1 being population and public health campaigns and box 2 being the risk factors that are identified, usually through primary care, your question relates to the population, where inequalities manifest themselves. 'Our Healthy Future' is the strategy that we are following and 'Fairer health outcomes for all' is the inequalities action plan, but we expect health boards—Chris mentioned the directors of public health—to understand their local community. For example, if you are Aneurin Bevan LHB, you will understand how the differences relate to each local authority area and neighbourhoods in your patch. You will work through the health and social care wellbeing strategy to try to address those determinants, with a focus on the areas of greatest need, and you will have measures for whether you are making progress or not. We know that inequalities manifest themselves in the most powerful way in stroke risk factors and cardiac risk factors. That is shown by such things as smoking rates by quintile—quintile 5 has three times the smoking rates of quintile 1, so we know that smoking is one of the drivers of persisting health inequalities in Wales.

[174] To answer your question to us, as the Minister sets out in 'Our Healthy Future' and 'Fairer health outcomes for all', we expect local health boards, working in partnership with local authorities, to have local health and social care wellbeing strategies, and a local public health strategic framework, linked to the 'Fairer health outcomes for all' action plan. The measures that they use are measures that we also see at a national level. Yesterday, I visited the Cwm Taf public health team and we talked about all these issues, including, as the Minister said, how effectively it is working in the Communities First areas and so on locally. I met several community leaders, who were not professionals, but who were working in their local communities on tobacco, obesity and so on. So, that is the way that we see it: there are national policies, and local health boards are leading in partnership with local authorities, looking at data and working with communities. We have an objective to reduce health inequalities and we are measuring it and actively pursuing it.

[175] **Lesley Griffiths:** To add to that, there is an action point in the risk strategy that I think has not been looked at enough, which is linking in to community food co-operative programmes. No specific work has been undertaken on that yet, because the co-operatives are being looked at now to ensure that they are sustainable, but that would be one area where we

could really target inequality. So, we are looking at that. Although it is in the plan at the moment, it has not had much work done on it and it is on hold, but it is certainly something that officials will be looking at in the development of the national stroke delivery plan.

[176] **Mark Drakeford:** On this inequalities issue, I have questions from Lynne and then Kirsty.

[177] **Lynne Neagle:** You have put the health inequalities issue in the public health box, but it could also be in the service provision box. We know that, for example, the south Wales Valleys have higher levels of all of the risk factors that we have talked about this morning. To what extent are you confident that such things as TIA interventions are being prioritised in the areas that we know have the highest incidence of these problems?

[178] **Dr Jewell:** You are absolutely right. I was not trying to suggest that it is in one box only, because 'Our Healthy Future' is about all of us—the Government, individuals and everybody. So, it is not a question of doing that; it is just where the emphasis was in terms of strategies and monitoring. However, you are absolutely right, and one issue is looking at to what extent there are measures of need. For example, if you were to look at emergency admissions for heart attacks or stroke in the south Wales Valleys, you would see that they are high, and then if you were to look at whether that population is receiving some other effective treatments, you might find that the figure is relatively low—lower than you might expect. We expect the local directors of public health working in the health boards to look at that data; it is available through health maps and other mapping through the NHS Wales Informatics Service system, so you can see the maps and that there is sometimes a gap between evident need and supply. Locally, that needs to be pursued through the different measures that we have, whether it is in primary care through QOF, which we were discussing earlier, or whether it is through the hospital sector, by asking, 'Why is it that so few people from this area are having this intervention, because we would expect it to be higher than it is?' That relates to the inverse care law that I referred to earlier. It was described in 1972, and we are still struggling to address it, but we now have better tools to try to drive this forward through the integrated health boards. Essentially, that is the new opportunity for us, in a way. By having integrated health boards, there should not be these fences up between primary, secondary and tertiary care; there should be an integrated system.

[179] **Kirsty Williams:** Dr Jewell, you very eloquently described how inequalities are being addressed outside of Government, but we know from the Marmot review that, if you want to do something about health inequalities, it is not the health service you have to worry about; it is through the education service and economic development policies that you really drive down health inequalities. I am interested to know, Minister, what discussions you are having at a Government level with the Ministers for education and economic development so that interventions in those departments address health inequalities. We know that the health service is picking up the pieces resulting from the failures within economic development, education and other departments. Where you really tackle the inequalities is through changes there.

[180] **Lesley Griffiths:** We have discussions across Government. Housing also has a huge role to play. Tomorrow, the Minister for Housing, Regeneration and Heritage and I are both attending a conference that links housing and health. There are discussions. As you say, that is the way to tackle health inequalities. So, I have discussions with Ministers, and officials also discuss these issues.

[181] **Gwyn R. Price:** After the first stroke, what action is taken to prevent further strokes?

[182] **Lesley Griffiths:** After the first stroke, primary care has a role in monitoring, and secondary care also has a role. We know about anticoagulation treatment, and, as we

mentioned earlier, a TIA is often the first indicator that there is a much bigger stroke coming. Again, the fact that the local health boards are much more integrated and setting the direction mean that there is much more integration between the two now to ensure that the person who has had a stroke has the risk of another reduced. This is all about stroke risk reduction, and we probably need to do a bit more to make sure that people who have had one stroke do not go on to have another. There is a great deal of work going on in that area. I do not know whether anybody wants to add anything.

[183] **Dr Jones:** There is quite a lot of clinical guidance out there about tertiary prevention in public health—that is, which drugs have an evidence base for use: aspirin, cholesterol-lowering drugs, some types of vasodilator drugs as well. The Royal College of Physicians' central clinical audit, which you are very well aware of, looks at some of these aspects and reports to us. The hospital-based clinical community is pretty well aware of this medical aspect of care, and the GP communities would recognise that these are high-risk patients for further events. We are back into the field then of quality assurance of general practice, around the efficacy of blood-pressure lowering in the community, and this kind of thing. There are different investigations that are appropriate for young patients with stroke, and they need different types of investigations to look for persistent holes in the heart—which lead to clots flying up—and the possibility of closing holes like that. Clinical colleagues are quite well aware of that. There is a lot of awareness in hospital practice about some of the work that needs to be done, and it extends back into primary care.

[184] **Gwyn R. Price:** I admire the prevention part of it, but I am afraid that, after a stroke, some people are just left without further attention. That concerns me. The prevention is great, and that is what we all want, but it is the follow-up after that first stroke that concerns me.

[185] **Lesley Griffiths:** It is about getting rapid treatment and medication, and, as I mentioned before, about whether it has been caused by a bleed or a clot—that is very important to know, and then that person would get the most appropriate medication and treatment. That is being done, but you are right to say that more work needs to be done on that.

[186] **Dr Jewell:** This is my box 3. The bundles of care have been very well described in our intelligent targets. For example, there is a bundle for what should happen in the first three to four hours, followed by the first day bundle as to what should happen in the first 24 hours. We then move to the first three days bundle and the first seven days bundle. So, essentially we are thinking about these treatment periods after someone has had a stroke, with the intention that they get discharged to have further rehabilitation if that is needed. On those four bundles or intelligent targets we are achieving uptake of 96 per cent, 83 per cent, 95 per cent and 95 per cent respectively. That should reassure you that, when someone has had a stroke, these targets are being implemented in the NHS in Wales, and they are staged in the length of days that you would expect someone to perhaps be in hospital, namely a week to 10 days.

[187] **Mark Drakeford:** We have heard from earlier witnesses that preventing a first stroke has had lots of policy attention, but there has not been quite as much attention given to what happens to people who have already had one stroke. It is interesting to hear that there may be more going on than we realised there.

[188] Diolch yn fawr i chi i gyd; thank you all very much for being here this morning. It was a helpful end to the oral evidence that we have taken for this inquiry. We will be working on our report and hope to publish it before Christmas, and we look forward to hearing your response to whatever recommendations we make.

[189] Just before we move to our next group of witnesses, because I know that not everybody can necessarily be here right to the very end, I wonder if I could ask you two

quick, practical things that, normally, I would come to at the end. The first is that we have heard previously, and again this morning, about the Scottish model of community pharmacy provision, and our clerks have made some contact with community pharmacy interests in Scotland. They are happy to give evidence to us over the video link later in our inquiry, and I just wanted to check that you are happy to go ahead and put that into our programme. I see that you are; thank you very much.

11.30 a.m.

[190] Secondly, for next week, in the afternoon of Thursday 10 November, we will have an informal session, so not a public session, where we will have Daniel Greenberg to help us develop our approach to legislative scrutiny. So, it is a chance for us to think about the tools, techniques and approaches that we will want to do that. Given that not everyone will be able to be there, I want to float with you the suggestion that we should be willing to allow Members to send a member of their staff to listen in to that session, so that they can come back and take notes. Even if Members are able to be there, they might want to bring someone with them, because you can be concentrating hard on what you are hearing, but need to be reminded afterwards. So, are you happy that we allow that to happen?

[191] **Kirsty Williams:** We heard from him in the Constitutional Affairs Committee at the end of last term, and he is very good.

[192] **Mark Drakeford:** Brilliant. We shall look forward to that and to getting full value out of him by having staff members there who also need to develop their expertise in this area to assist us with our further work. Diolch yn fawr.

11.31 a.m.

Ymchwiliad i'r Cyfraniad a Wneir gan Fferyllfeydd Cymunedol i Wasanaethau Iechyd yng Nghymru: Tystiolaeth gan Gynrychiolwyr y GIG
Inquiry into the Contribution of Community Pharmacy to Health Services in Wales: Evidence from NHS Representatives

[193] **Mark Drakeford:** Bore da a chroeso. Diolch yn fawr i chi am ddod yma'r bore yma. Yr ydym yn awr yn dychwelyd at yr ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru. Diolch yn fawr i Chris Martin, cadeirydd Bwrdd Iechyd Lleol Hywel Dda, am ddod yma bore yma. Croeso hefyd i Berwyn Owen o Fwrdd Iechyd Prifysgol Betsi Cadwaladr, sy'n gyfarwyddwr rhaglen genedlaethol rheolaeth meddyginiaethau, ac i Bernardine Rees, sef cyfarwyddwr gweithredol gofal iechyd sylfaenol, iechyd cymunedol ac iechyd meddwl Bwrdd Iechyd Lleol Cwm Taf.

Mark Drakeford: Good morning and welcome. Thank you very much for attending our meeting this morning. We now return to our inquiry into the contribution of community pharmacy to health services in Wales. I thank Chris Martin, chair of Hywel Dda Local Health Board, for coming along this morning. I also welcome Berwyn Owen from Betsi Cadwaladr University Local Health Board, who is director of the national medicines management programme, and Bernardine Rees, who is the executive director of primary, community and mental health care of Cwm Taf Local Health Board.

[194] So, we return to the topic with which we began the morning, when we considered evidence from general practitioner interests on the contribution that community pharmacy can make to future health services in Wales. Chris, I invite you to introduce these issues from the perspective of the panel. We only have three quarters of an hour, so will have to move fairly rapidly through the questions. I therefore ask you, Chris, to identify which member of the

panel is best placed to answer these questions, rather than expecting an answer from each of you to every question.

[195] **Mr Martin:** I will make the introductory remarks on behalf of the three of us, rather than the three of us doing it separately. I thank you for the opportunity to provide information towards this inquiry. As you said in your introduction, Chair, I am the chairman of Hywel Dda Local Health Board, but I have spent most of my professional career as a community pharmacist, so I hope that I would have a unique insight into the challenges and the opportunities facing my profession and the LHBs over the past few years. As you are probably aware, I was invited by the previous Minister for Health and Social Services, Edwina Hart, to chair the task and finish group that was set up to review pharmaceutical services across Wales, which morphed into the strategic delivery group. During our work, we grappled with the same issues that you are trying to investigate as part of your work on this committee. I hope that you have had sight of the 'Emerging Themes: Improving Pharmaceutical Services in Wales' document, which was published in September 2009, and updates given to the national advisory board by my colleague Mel Evans, who is now chair of Powys Teaching Local Health Board. If you have not received those, we will ensure that you receive copies after the meeting. My colleagues to the left and right of me have been introduced to you and, as requested, we have all provided you with formal responses from each of our organisations.

[196] I have spent most of my professional career, as you know, as a successful community pharmacist. I say that because we provided high-quality care to our patients and customers, linked to a very efficient supply of medicines and public health messaging. That is true pharmaceutical care, as part of an integrated primary healthcare team, and I would hope that we will be able to explore that today.

[197] I hope that my colleagues have seen me as an innovator. I set up the first pharmacy development group in Wales, the Pembrokeshire pharmacy forum, and some 10 years ago I was holding asthma clinics with practice nurses, having breakfast meetings with my GPs to discuss prescribing guidelines and offering osteoporosis screening for at-risk groups. The list goes on. All of those things were linked to pilot moneys, which caused some frustration in the old LHBs—we suffered from good old 'pilotitis', as a diverse set of principles and priorities in service developments emerged over many years. I suppose that that was in response to local priorities and, in some cases, to pharmaceutical needs assessment, which we can perhaps explore today. In reality, we had a mixed bag of enhanced services right across Wales, and there was not too much sharing of best practice.

[198] The new pharmacy contract was implemented in 2005, which introduced the medicines use reviews as the first advanced services. The LHBs saw this as an opportunity for community pharmacy to add some extra value to the medicine supply chain. However, I am sure that you have seen some mixed responses to that, certainly from community pharmacy, and other professionals. The contract continues as a national contract, which is negotiated in England on behalf of Wales and which is adopted by Wales. I believe that we are in a place where we need to scope out the capacity and resource needed to develop a new Welsh contract for community pharmacy, and I would be very happy to help with that process, if you saw fit.

[199] With regard to the strategic delivery group and the emerging themes document, some really good recommendations were made, and we have made significant progress. Many of the recommendations, which I hope we can share with you today, including waste medication awareness and the national directed enhanced services, standardised patient group directions, service specifications, training accreditation requirements, fees and allowances, and a whole range of other things that I will not go into now. We have made significant progress in many of those areas. We have been developing pharmacists' role in palliative care and other areas.

[200] I have always believed that pharmacy has been underutilised and undervalued, and I know that there has been frustration with differential service developments across Wales. However, in our new LHB world, and with the new Chief Pharmaceutical Officer for Wales, Professor Roger Walker, at the helm, a group of primary, community and mental health directors and chief pharmacists in each of the LHBs are ready to support their roll-out. I would hope that we are in a better place than we have ever been before. However, my professional colleagues need to step up to the plate, embrace the opportunity, fully integrate themselves into the patient pathway and deliver added-value services on behalf of the citizens of Wales. We must work together to help shape this future and understand each other's challenges and deliver better patient outcomes. My greatest fear is that my profession will not deliver on this expanding role in sufficient numbers to provide fair and equitable service provision. We must not let this happen. Diolch yn fawr.

[201] **Mark Drakeford:** Thank you, Chris. Members are quick out of the blocks this morning; I saw William Graham indicating first, followed by Rebecca and then by Kirsty.

[202] **William Graham:** Thank you for the papers you have given us today. Do you feel that there is a need to raise the profile of pharmaceutical care, especially at an executive level? How could that be achieved?

[203] **Mr Martin:** Yes, I would agree. There was a pharmacist board member on the old LHBs, which was a good thing, as well as the heads of medicine management, who were the key people who were helping to drive forward service developments. At the moment, we have the health professions forum, and community pharmacy has a seat at that table. There is a stakeholder group in each of the LHBs—and my colleagues can share this information with you—where a community pharmacist comes along, and which meets normally with the director of primary, community and mental health services.

[204] There is certainly access within the organisation, but is it at a high enough level? I would hope that they would be lobbying health boards to come to do presentations. That has never happened, certainly in our locality, and that is a missed opportunity. We need to understand more. I have always seen community pharmacy as a silent profession, but they need to shout more about what they can provide in delivering better patient care.

[205] **Dr Owen:** There are huge national expectations within health boards regarding medicines management. Pharmacy, clearly, is an effective custodian and manager of medicines. As we increasingly depend on medicines and their interventions, with the growing age of the population, I have confidence that the pharmacy teams within health boards and our communities are effective managers of this agenda. There are significant opportunities with the use of medicines as regards the prevention agenda and public health. I feel that community pharmacy, in particular, is best placed to provide both of those aspects.

[206] We are a profession that has had to change, given that we were historically seen as being in the backroom of pharmacies, involved in the dispensing of medicines, as the custodian of medicines. Increasingly, we have a profession that is having to shift from a scientific basis to a more social science basis, where we learn skills around behavioural management, motivational support and others. That is where we are seeing the fruits of the new contract—where we are involved in a lot of the screening and the public health campaigns.

[207] **Ms Rees:** I assure you that the profile of medicines at board level is currently through the directors of primary and community care, the portfolio that I hold, and it is also within the portfolio of the vice-chair of local health boards. The profile is very much in evidence at the minute, because medicine runs through everything that we do in terms of the way in which we

deliver a whole system—it is almost the glue that holds some of the interventions together. We have missed opportunities in the past, even when we had profiles at board level, so there are systems and processes now available that we can explore during the session to raise the profile, but we may not necessarily have those individuals at board level.

[208] **Rebecca Evans:** What capacity issues have you encountered in community pharmacy in terms of the ability of the sector to respond to the demands that have been put on pharmacists by the new tasks and services that they have been asked to undertake?

[209] **Mr Martin:** That is a very good question in respect of how we make sure that the profession steps up to the plate and delivers on the agenda, when we are looking for pharmacists to undertake more enhanced services. As I said in my introductory comments, we need to look at the contract, because it is a volume-based contract. That in itself is difficult in terms of managing the added-value services that you want to add to that contract. Where there has been huge success within community pharmacy, people have invested in helping and supporting their staff so that they work as a team. We are seeing accredited checking technicians taking on enhanced roles within the pharmacy setting, which releases time for the pharmacists to take on a more professional role. We need to look at what is happening in secondary care, and that is a good example of where that has happened. So, we need to encourage pharmacists to support their staff to better themselves, but also to work more collaboratively as a team to deliver on what we would hope they will deliver in the future.

[210] **Ms Rees:** The way in which the contract is set out means that we deliver medicines in silos. We need to look at how community pharmacy can contribute to a whole system by working with other professionals and using the opportunities, remembering that community pharmacists are independent contractors.

[211] **Rebecca Evans:** We have heard evidence about pharmacy-led public health campaigns, particularly the diabetes campaign that took place over the last few months. It was poorly taken up in Ceredigion and Pembrokeshire, in particular. What are the reasons for that lack of participation? Is it because pharmacists are not equipped to do it? Do they not want to do it, or is there a lack of leadership from the LHBs?

[212] **Mr Martin:** We need to respect the fact that they are all independent contractors, and, having listened to the earlier debate about GPs, you also need to respect that with regard to GPs. You are, therefore, looking for community pharmacists to be involved in it on a voluntary basis. I would hope that it is not due to a lack of leadership within the locality. That campaign, as you know, was spearheaded by Community Pharmacy Wales, and it was a great example of where pharmacy can get behind a public health campaign to drive forward an important message within our communities. I am disappointed to hear what you say; I will investigate more when I go back to find out why we were not up to the mark, and I will make sure that we are in future.

[213] **Mark Drakeford:** You have put your finger there on a real difficulty for this committee. Were we to recommend to the Welsh Government that community pharmacists could take on more services that are currently universally provided and shift them from where they are now to community pharmacists, how could we confidently do that on the basis that all of your members are volunteers and may or may not decide to do it?

[214] **Ms Rees:** There is an issue about the way in which we incentivise independent contractors. We have enhanced services within general practice and community pharmacy. What we need to do is to run them together, so that when we are looking at a whole system, we are very clear as to who is doing what with regard to pathway development. However, there is also an issue around public acceptability. We have 70 community pharmacists within Cwm Taf, and we arrange our localities into four areas. We have clusters within those

localities. So, it is not beyond us to work through a full pathway that includes community pharmacy and general practice and other professions in our delivery to our localities, and that is particularly pertinent in rural areas.

11.45 a.m.

[215] **Mr Martin:** I would come back to the point that we may need to look at the contract in terms of the opportunities going forward. Certainly, across the UK, if you look at what is happening in Scotland, and in England now, you will see that there is a real opportunity here to scope that out and to see whether we can change the contract format to help with looking at things such as advanced services and perhaps to extend national enhanced services, which was among the recommendations that came out of the strategic delivery group. The first was EHC, and we are going to go on to smoking cessation and then supervised methadone and so forth. I think that there is an opportunity for us to do things differently, but we need to go back and look at the structure of the contract, and then take people with us.

[216] **Kirsty Williams:** Mr Martin, you say that we need to go back and look at the structure of the contract. Unfortunately, I have been around long enough to remember the negotiations that led to the contract back in 2005. At no stage in those discussions were these issues highlighted. In fact, what happened in 2005 was that we were promised a revolution in how pharmacy services would be delivered. Of course, part of that was going to be the role of local health boards, in being able to commission services. Indeed, one of the first questions in this consultation was about the level to which local health boards have engaged in that agenda.

[217] Mr Martin, you certainly talk the talk, but in your paper, examples of services that your local health board, Hywel Dda, has commissioned are few and far between; fair play to Cwm Taf, there is a longer list there. What I need to understand, as I do not understand it at the moment, is that you have had the ability to do this since 2005, yet local health boards have not particularly engaged in this agenda. There is a long list of reasons in the paper from Hywel Dda. It seems to be everybody else's fault that this has not happened, and there is little acknowledgement of anything that the LHB could have done to have made a better job of it. I just do not understand why local health boards have not taken on this agenda. Your local health board, of the three appearing before us, seems to be the worst.

[218] **Mr Martin:** I have always struggled, because there is a conflict of interest in having a community pharmacist as the chairman there, so I have tried not to get involved in steering the way in which the health board works with community pharmacy. We are in the position—certainly, the MURs are, as part of the original contract for the advanced services—of not having seen as good a take-up as we might have in terms of the activity. The enhanced services were normally looked at from the perspective of a public health campaign, and among the things that were missing at the time was the evidence to support some of those being delivered. You will see that it is a mixed bag across Wales—you are absolutely right. Torfaen really grabbed the opportunity, because of the good relationships that it had. I would like to see the evidence now, to see what that has delivered for its population and how that has changed.

[219] At the time, we invested in the pharmacy team in our health board to try to look at medicines management and to look at cost-effective prescribing. That is where the focus was for us. Did we miss a trick at the time? Well, as a community pharmacist, I would say that, yes, we did. It therefore feels as though we need to embrace the opportunity, and that is why the strategic delivery group suggested that we needed national enhanced services that are common to all, that are standardised, that we could then deliver consistently across Wales rather than having this position.

[220] We are in a different place now, because we have seven health boards, and we have that direction of travel. I know that the chief pharmaceutical officer is very keen on making sure that we have a roll-out of some of these key areas.

[221] **Kirsty Williams:** So, God willing, if I am on this committee in five years' time—

[222] **Elin Jones:** You will be here. [*Laughter.*]

[223] **Kirsty Williams:** It is five years since I last sat on this committee and heard all of this, so what kind of level of service will I be looking at? Will I be sitting here with another local health board chairman before me saying, 'Ah, well, what we need to do is reorganise the contract, then we can do it'?

[224] **Ms Rees:** History has to influence the future, and all that you have described I recognise as the director of primary and community care at Hywel Dda at the time. One of the big things for the future—the position that I described earlier—would be if, as a member of the public, I could go to my pharmacy as the first port of call. I would know that I could get good, sound advice and a good medicines review because there would be a quality and a standard attached to that. We missed opportunities in the past during the integration of the new local health boards. We have a new, all-embracing strategy called Setting the Direction, which sets how we manage our population regarding self-care, interventional care and access. That is the future, and if you and I, Kirsty, are still around in a few years' time, we will be able to access it ourselves. It is about maximising the opportunities. It is not about working in silos, as we had to previously.

[225] **Vaughan Gething:** On maximising opportunities, we have heard a bit about how the contract does not have the ability to do everything, yet your evidence differs. Betsi Cadwaladr says that the contract has enhanced contribution. Hywel Dda says that it has the potential to do so, although it cannot list anything that it has effectively done. Cwm Taf is able to list a number of things that have been done. There are three different health boards with three different outcomes. Two have taken up a number of opportunities and one cannot evidence that it has. So, it cannot all be about the contract. Are you sharing your different experiences? If you are not talking to each other, it may be useful to tell us why. How does Betsi Cadwaladr think that it has managed to achieve that, and what sort of a lead has it given as a local health board to see that happen?

[226] **Dr Owen:** Historically, when we had 22 local health boards, there were different relationships between the health boards. We appointed heads of pharmacy and medicines management in each health board and we had pharmacy board members and community pharmacists. Therefore, there was variation and it was a new contract with the formation of the new health boards. The pace at which some of those health boards commissioned and planned those services varied. Betsi Cadwaladr's relationships were mature, but we were able to look at evidence elsewhere regarding prioritisation and where the biggest impact would come from, for example, in developing enhanced services and where to target. That is why we started with the emergency hormonal contraception, followed by smoking cessation—I add that the evidence based around them was poor at the time. On this journey, we have improved. It is where the strategic delivery group came into its own, in that we had this variation and we had to address it. The strategic delivery group, through Chris's chairmanship, has enabled us to have a much more uniform approach to the planning of enhanced services in Wales, so that all seven health boards can come together to plan that.

[227] So, it is based on evidence and building that evidence. We now have national electronic claims for enhanced services established for emergency hormonal contraception. That is giving us data collection outcomes. We have now extended that to smoking and are seeing that four-week quit rates measured across Wales are equivalent to, if not better than,

some areas of Stop Smoking Wales. Again, it is about building the evidence base of what has historically been quite an immature area. Relationships have improved and we have a much more consistent approach. We have a medicines management programme in Wales that looks at minimising waste, harm and variation within medicines management. That is another lever for us to ensure that there is now consistency across the country.

[228] **Mr Martin:** I endorse what Berwyn said. We are in a better place now, because of the consistency of approach that we achieved through the strategic delivery group. We were in a difficult place before, as we had 22 views on taking different services forward. In Scotland, the view was taken to look at national enhanced services—that is definitely the way in which we should be going. That is what was endorsed by the strategic delivery group. The inconsistencies that you have identified will, hopefully, in the future, be managed more effectively.

[229] **Elin Jones:** In your introduction you were clearly of the view that it is time to consider a Wales-only contract. We have not had much evidence to that effect or against that proposition to date. Can you tell us how widespread the support for that would be among local health boards and, in your particular case, community pharmacists in Wales? We had evidence earlier this morning from GP representatives, and there was a degree of resistance or questioning of the role of enhanced services in community pharmacies and how successful that could be. Some of their resistance came from the fact that there could not be a guarantee of shared information between GPs and community pharmacists. We have heard previously that this is a weakness in the system currently in the rolling out of enhanced services in particular. This morning, we discussed flu jabs for example. As local health boards, how do you view the greater sharing of information—individual patient information in some cases—between community pharmacies and GP practices? Finally, as you are a community pharmacist, Chris, do you get an invitation to your local GP's Christmas party?

[230] **Mr Martin:** I was many times the star performer. [*Laughter*.] In fact, on that point, it is based on relationships, and we had a mutual respect for each other's roles in patient care. Absolutely, I was always invited to the GP Christmas party. I will pick up on the first part of the question, and then I will ask Berwyn to pick up on the other bit about IT and information. I get the sense that there is now a feeling among the LHBs, because we have different health policies and because there is a divergence in health policy across the UK, that we should be looking at a community pharmacy contract just for Wales. However, I think that it needs to be mapped out effectively, and we have got to ensure that we have a position that does not disincentivise the supply function, but bring added value to it as part of the process. So, the answer to the question is, yes, I think that there is now a momentum building that that should be explored and looked at seriously as the way forward. I would welcome that opportunity. Berwyn, do you want to pick up the other bits of the question?

[231] **Dr Owen:** Sure. Thanks, Chris. Very briefly, in response to the first issue you raised, Elin, about GPs and their concerns about the value of enhanced services, if I understood your question, again, that comes down to local relationships. We have evidence that, in some areas, GPs highly value some of the enhanced services. For example, through the rural health programme, we are now testing an enhanced service that I understand you have already been briefed on, namely CBT in a rural pharmacy setting. In effect, that programme is web-based. The patient will enter the consultation room in a pharmacy and have, over eight sessions, an eight-hour cognitive behavioural therapy session via the community pharmacy. The pharmacy role there is to ensure that the relationship builds with that particular patient. GPs are now referring people to that service in those rural areas, so there is a change happening in the understanding and trust being built between the two.

[232] On information, again, this is an area where, because of the development of the clinical portal with NWIS nationally, we are now testing out a new approach that has been

developed in Cardiff and Vale University Local Health Board: the national transcribing module. That enables the whole pharmacy family to view, for example, the medicines, regardless of the practitioner or setting. That will enable drugs information to get into the hospital and medicines information to come out of the hospital back into the community. All of that will be improved—the whole reconciliation service. That is where a great deal of harm occurs, during the transfer from one sector to the other—from community services to acute services and vice versa. So, we are focusing ruthlessly on that area at the moment to try to improve some of the performance in those areas.

[233] **Elin Jones:** Is that being done on an individual basis? Is an individual patient record, in terms of medicine, potentially transferable between pharmacists, hospitals and GP practices?

[234] **Dr Owen:** Yes, that is right. On the QOF, I would say that, in all health boards now, pharmacy is part of the steering groups within locality development in Wales—we refer to networks or localities. So, through locality development, we are using things such as the quality and outcomes frameworks we have in general medical services to look at opportunities to go upstream to manage things such as prostate cancer and to identify them sooner and enable treatment sooner. It is about marrying, at locality level, the multidisciplinary team around the table to ensure that we target patients sooner.

12.00 p.m.

[235] **Vaughan Gething:** I will ask about the evidence that we heard this morning from the doctors about where the line is drawn regarding the value of treating minor ailments and the scope for that provision. You note that a national minor ailments scheme would require Welsh Government funding. Where do you see the scope to roll out an additional role for community pharmacists, and what is the value of that? Is it about cost saving or freeing up time for other practitioners?

[236] **Ms Rees:** It is about looking at what we need to be able to access as individuals. There is huge opportunity in the wealth of knowledge of community pharmacy. There are professional boundaries that we have to work through. There is the issue of public acceptance as regards people going to their pharmacist before going to a GP. A conversation I had this week in a service review, with a GP and a community pharmacist, articulated what I have just said. The doctor was saying that the patient would go to him anyway and the pharmacist was saying that he could do some of that work. As an NHS manager, and as a patient, I said that I would want the quickest access and the best intervention. I do not want to be waiting. I want the doctor to do what only the doctor can do, and the pharmacist to be able to use his skills to provide reassurance in relation to minor ailments.

[237] **Vaughan Gething:** To go back to professional boundaries, this point has been raised in lots of the evidence, and the doctors today confirmed in the clearest terms possible that there are professional boundaries. From the LHB point of view, how do you address those professional boundaries to get these people to come together? The rhetoric was, ‘We want to work more closely together, but we cannot’. However, that does not appear to be the case, because in some parts of the country they work more closely together. It is about leadership and direction from the LHB level as well.

[238] **Ms Rees:** It is about Setting the Direction, and the opportunity is there within the LHBs. However, I challenge Community Pharmacy Wales. It has an opportunity to help LHBs to deliver that. It recently published a manifesto, and if you look at the strands through the manifesto, they do not marry well into Setting the Direction. In the way we manage and work with community pharmacy, we do not allow it the flexibility, as an independent contractor, to provide for some of those ailments. We all know and share the pressure on GP

surgeries in terms of access. We have got to get the right place, time and intervention for the patient. We have a leadership role, as local health boards, in that. Most of us are now going through service reviews. We are looking at the appropriate lowest denominator for patients in terms of access. I described earlier in my response to you a service review where we were doing that. It is for us to work through the differences and policy to support that, and for individual professionals to look at their own professional accountability.

[239] **Mr Martin:** It is about having that mutual respect for the contribution that each party can make. It is about those local relationships. So, rather than only being contacted by the community pharmacy because there is a mistake on a prescription, you are actually talking about patient care. We all need to try to help to break down those barriers and support opportunities to have joint continuing professional development sessions to bring people together to have a better understanding of what value they can bring to patient care. So, yes, we have a role to play, but it is also about that communication link. That is what worked for me in the past when I was a practising community pharmacist. It is fantastic when it works effectively and you have that professional feeling of having made a difference. That is the bit that we have got to grasp.

[240] **Gwyn R. Price:** Do you think the pharmacy and GP contracts help or hinder the process?

[241] **Ms Rees:** They both help and hinder. I am sorry that I am sitting on the fence.

[242] **Gwyn R. Price:** You are not a politician, are you? [*Laughter.*]

[243] **Ms Rees:** No, I am a nurse, and I look at it through the lens of the patient. Everything that I do and the values that I bring to the NHS are through the lens of the patient. We have to scope out where the differences are, but also recognise where the similarities are, so that patients are not confused about where they have to access services. That needs some work, leadership and courage as well as the ability to be able to bring those parties together through a common contract in terms of enhanced services through clear pathways.

[244] **Gwyn R. Price:** Having listened to the doctors as well, all of you seem to be saying the same thing, which is that you do work together, but not everywhere, perhaps. The patient is the main person in this, and when they come along, they want to know whether they can go to their pharmacist and not bother the doctor, and vice versa. That is what we are concerned with.

[245] **Mark Drakeford:** I want to ask one last question. If we were able to strip away all the contractual difficulties, the professional turf wars and all of that, the basic proposition put to us at the beginning was that pharmacists could do more to displace work away from GPs. That would allow GPs to concentrate on those patients who are more fragile and need more intervention, which would mean allowing them to manage in the community people who currently end up in secondary care. Therefore, the savings in the system would be realised in secondary care. They are cascaded down through the whole system—making a change at the primary and community end means that you save money in the end because people who do not need to be in hospital are no longer there. You could argue that LHBs, in their new configuration, have a unique opportunity, because they are integrated organisations that are able to take that whole-system view of things. Do you think that the proposition is true, and, if we were able to do it, could it do what is claimed on the tin, as it were? Secondly, do you think that LHBs are making maximum use of the new opportunities that they have to make that happen?

[246] **Mr Martin:** For me, they have to be integrated in the patient pathway. As part of our clinical services review, as Bernie alluded to, we are trying to understand how each of those

independent contractors within primary care makes a contribution to helping and supporting that journey more effectively in terms of chronic conditions management. As you rightly say, this would stop those patients who are frequent flyers from going into hospital all the time. There is a real opportunity here. We should be doing more in terms of making sure that that happens and, as part of the reviews that we are undertaking now, we are going to grasp that opportunity. The way that LHBs are configured gives us an opportunity like we have never had before, because they are integrated organisations like we have never had before. If we cannot do it now, we will never do it, and I do not want to be here in five years' time, either, telling you that we failed. This is a massive opportunity.

[247] **Mark Drakeford:** Thank you very much for being here this morning, and helping us with our inquiry. We have had some interesting and useful material. Diolch yn fawr iawn. Thank you to members of the committee. It has been a long morning between everything, so I am grateful to you all too for your patience in sticking with the agenda. We meet again on Thursday of next week.

Daeth y cyfarfod i ben am 12.08 p.m.
The meeting ended at 12.08 p.m.