



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

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

Dydd Mercher, 16 Tachwedd 2011
Wednesday, 16 November 2011

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Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public from the Meeting for Item 6

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

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

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

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

Eraill yn bresennol**Others in attendance**

Melanie Gadd	Cydlynnydd Prosiect Jiwsî, y Gymdeithas Cynllunio Teulu Jiwsî Project Co-ordinator, Family Planning Association
Jason Harding	Rhelowr Polisi a Materion Cyhoeddus, Diabetes UK Cymru Policy and Public Affairs Manager, Diabetes UK Cymru
Sue Thomas	Cynghorydd Gofal Sylfaenol a'r Sector Annibynnol, Coleg Brenhinol y Nyrsys Cymru Primary Care and Independent Sector Adviser, Royal College of Nursing Wales
Lisa Turnbull	Cynghorydd Polisi a Materion Cyhoeddus, Coleg Brenhinol y Nyrsys Cymru Policy and Public Affairs Adviser, Royal College of Nursing Wales

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

Steve Boyce	Y Gwasanaeth Ymchwil Research Service
Llinos Dafydd	Clerc Clerk
Mike Lewis	Dirprwy Glerc Deputy Clerk

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

**Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions**

- [1] **Mark Drakeford:** Croeso, a bore da i bawb. Cynhelir y cyfarfod yn ddwyieithog. Yr ydym wedi cael ymddiheuriadau oddi wrth Darren Millar a Lynne Neagle.
- Mark Drakeford:** Welcome, and good morning, everyone. The meeting will be held bilingually. We have received apologies from Darren Millar and Lynne Neagle.

9.31 a.m.

**Ymchwiliad i'r Cyfraniad a wneir gan Fferyllfeydd Cymunedol i
Wasanaethau Iechyd yng Nghymru: Tystiolaeth gan Goleg Brenhinol y
Nyrsys Cymru**
**Inquiry into the Contribution of Community Pharmacy to Health
Services in Wales: Evidence from the Royal College of Nursing
Wales**

[2] **Mark Drakeford:** Croeso i Lisa Turnbull, cyngorydd polisi a materion cyhoeddus Coleg Brenhinol y Nyrsys Cymru, ac i Sue Thomas, cyngorydd gofal sylfaenol a'r sector annibynnol. Diolch yn fawr i chi'ch dwy am y papurau a dderbyniwyd cyn y cyfarfod. A oes gennych unrhyw sylwadau byr cyn symud at gwestiynau Aelodau?

Mark Drakeford: Welcome to Lisa Turnbull, policy and public affairs adviser with the Royal College of Nursing Wales, and Sue Thomas, primary care and independent sector adviser. Thank you both for the papers received before the meeting. Do you have any opening remarks before we move to Members' questions?

[3] We will start with any brief introductory remarks that you want to make to draw our attention to any key points in the paper that we have received, and then I will turn to committee members for questions.

[4] **Ms Turnbull:** Thank you for the invitation to provide the nursing perspective. We hope that we have constructive comments to make about increasing access to primary care and non-medical prescribing, and some of the wider issues that have come up during the course of the inquiry. We hope to be able to provide a nursing perspective on that.

[5] **Mark Drakeford:** I now turn to Members. Who wants to kick off? Rebecca, you can go first.

[6] **Rebecca Evans:** We have heard in our evidence that there should be extra advanced services for diagnostics provided through community pharmacies. What is the RCN's view on that, in particular on extra training that would be required and issues around accountability?

[7] **Ms Turnbull:** We would leave a specific, detailed question about community pharmacy for the community pharmacists to answer, but, generally, it sounds like a favourable development. You would need to be specific about what kind of a service you wanted in that area, and then look at whether any additional training would need to be provided for the specifics. Sorry, I cannot answer your question in more detail.

[8] **Ms Thomas:** Do you have any examples of the advanced diagnostics that have been proposed?

[9] **Rebecca Evans:** I do not think that we have had specific examples. However, we have been looking at a stroke inquiry, so diagnosing somebody with atrial fibrillation could perhaps happen through community pharmacy.

[10] **Ms Thomas:** RCN Wales has said that the easiest way to detect atrial fibrillation is by simply taking the pulse. Nurses are used to doing that on a daily basis. That would certainly be acceptable for nursing roles, and should not require any advanced training.

[11] **Rebecca Evans:** On a more general point, do you believe that community pharmacy services are sufficiently well integrated into other health services, particularly primary care?

[12] **Ms Turnbull:** Certainly, there is always more that could be done. One of the questions that we were discussing was improving the informatics structure, to support the work that all health professionals, not just community pharmacy, would do in the community. So, when looking at primary or community care services as a whole, more work needs to be done to integrate them and to ensure that the patient has the best experience.

[13] **Ms Thomas:** Over the last few years, since the training programmes have been in place for nurses and pharmacists to become non-medical prescribers, there has been a lot of shared learning. We have learned that, through the shared learning, there has been an understanding of each other's role. So, the pharmacists clearly have a grounded background in knowledge of medicines, and nurses tend to have more knowledge and experience of the clinical, hands-on management of patients and their conditions. That has been a nice working relationship; it has been seen in the classroom and could be demonstrated usefully in the pharmacy environment.

[14] I am not sure of any models where nurses and pharmacists work alongside each other. We are used to nurses working with general practitioners in primary care, and we are used to district nurses working in people's homes. It would be interesting to explore the notion of pharmacists and nurses working together to contribute their own areas of expertise. You would have to look at the different employment models. You could, for example, have a model where the independent contractor—the pharmacist—employs a nurse, or you could look to the health board to put a salaried option in place. You would have to see how the skills enable unscheduled care needs to be met in different ways, for example with out-of-hours services.

[15] **Mark Drakeford:** Most committee members have indicated that they have questions. The next three people will be Lindsay, Mick and William.

[16] **Lindsay Whittle:** I think, Sue, that you have practically answered my question with your last answer; thank you for that. Are you aware of any examples of nurses working in pharmacies? Judging by your answer, I do not think that there are any such examples.

[17] **Ms Thomas:** I am not specifically aware of any, but I wonder whether I have heard that one of the larger organisations is employing nurses, although I am not sure in what capacity. I do not know if it is to do with medicines management or the role in health promotion and advice. It would be interesting to explore the role in medicines management. One of the national pharmacies may have some health promotion nurses.

[18] **Lindsay Whittle:** I would have some concerns as to the professionalism of the nurse and the pharmacist being compromised in the same pharmacy. For example, if something went wrong, would the pharmacist blame the nurse and the nurse blame the pharmacist? That would worry me a little.

[19] **Ms Thomas:** You would want to see robust clinical governance and patient-safety policies and procedures in place.

[20] **Lindsay Whittle:** I would have thought that you would also need more adequate training.

[21] **Ms Thomas:** Yes, you would want to know that that was in place as a preliminary issue. You would have to look to the NHS or organisations that are used to dealing robustly with such issues, to see how that is translated into a different sector. Of course, we have independent sector providers of care in other ways, and they are used to having to satisfy Health Inspectorate Wales and other organisations that look very much to the governance

issues. You would want to ensure that that was in place to be satisfied.

[22] **Ms Turnbull:** It is not an insurmountable issue, because professions obviously work together very well in many sectors in the NHS. It is certainly not something that would prevent the development of that model.

[23] **Mick Antoniw:** When I was a child, the role of the nurse was, predominantly, to hand things to the top. That role has changed phenomenally over the past decade, to a sort of paramedical role. In GP surgeries, where practice nurses are predominately based, there has been a major transition with regard to training, prescribing and so on. Can you tell us little about how that has worked and developed? There was a lot of resistance to it initially, and a lot of concerns were raised. So, with GP surgeries moving down that particular road, can you tell us a little about the problems that you have experienced in consolidating that transition? What problems still exist? I would then like to follow that up with the community pharmacy aspect, but I will ask a separate question about that.

[24] **Ms Turnbull:** I will let my colleague Sue talk a little about the role of the nurse more generally, but I will make some opening remarks about independent prescribing, which has been introduced in Wales. We have seen the Welsh Government make an investment in providing training places for people to become independent prescribers. However, we have not seen that developed strategically in certain sectors. It has merely been people applying for the course in, more or less, an ad hoc fashion. We would like to see the development of that in primary care. One of the barriers to doing that is that, in order to go on the course, for example, you would need a mentor, someone who is an experienced prescriber, and that will more commonly be a medic. So, it is important to put networks of support in place in order to encourage the development of independent prescribing. I wanted to make those opening remarks to say that there have been some issues in terms of realising the benefits of non-medical prescribing in primary care. Perhaps you can say something about the role of the nurse, Sue.

[25] **Ms Thomas:** You are probably aware that nurses have been employed as practice nurses by GPs since about 1990, when there was a new GP contract and the Government said that it would be encouraging to have nurses undertaking roles in assisting with health promotion and the preventative agenda that we are looking towards in the health service. So, nurses came into a situation that previously was not very well explored, and maybe that is why you are asking the question to look at how a similar model could be developed. As a result of the lack of a strategic approach to that, it has depended on the GP practice seeking a nurse to employ. There have been interesting times, when a nurse has found themselves working outside the NHS and having to negotiate their contract and terms of employment. So, there are interesting situations around that. There is then the potential for each practice to function and operate differently. Since 2004, we have the GP contract, which standardises the care offered across the health service. So, there are also those considerations, which are to do with consistency and approaches, but recognising that the relationship is unique, where you have a member of staff who is employed by an independent contractor, which sits just outside the mechanism of the NHS that we all know and is a more familiar model.

[26] **Mick Antoniw:** How important is it, in terms of access to things such as medical records and background knowledge, to be able to consult with the GP within that role? I am thinking of things such as safety, clinical excellence and so on. There are so many medical matters that overlap, and that are affected by various conditions and so on. To what extent does that work? Has there been confidence and trust from the GP side to allow that to happen for the nurses?

[27] **Ms Thomas:** Very much so. Where the premises and the computerised system are shared, it is just a case of accessing a terminal that is linked to the system of that individual

practice. In a model where community pharmacy and general practice are linked for a wider team approach, you need connecting information systems, because you want to know that everybody has the same information about a patient so that anything that is important to know about that patient is considered. That is on the grounds of safety; you do not want to miss out that valuable bit of information that makes a decision important. So, where people are working within the same surgery, information and records are shared, because everybody has equal access, to enter or receive information.

9.45 a.m.

[28] **Ms Turnbull:** Looking across to England, the approach that they have used is the well-established walk-in centres. That is not necessarily the approach that we would want to follow, but when you look at the practice there and the ones that have been very successful, you will see a variety of healthcare professionals working to deliver care in a particular area. It could be that they are focusing on chronic conditions management, or it could be sexual health. They have taken a different approach in different areas, depending on the needs of the area, with a different mix of healthcare professionals, be they GPs, pharmacists or nurses. That would be an excellent model to look at, to see how such the system works with the other unscheduled care providers or the GP systems. That might offer a useful way.

[29] The other point that I want to add, going back to your point about accountability and the specific point about non-medical prescribing, is that the benefit of it is that there is a very clear legal and professional chain of accountability, as opposed to previous systems in which a GP, for example, could be accountable but may not be the person making the decision or handling the prescription, which could become an uncomfortable grey area.

[30] **Ms Thomas:** There is something in there about professional accountability and also about employer accountability, and the two things are different.

[31] **Mick Antoniw:** Following that to where it is leading, if you were to translate that into the growth or expansion of the role of community pharmacy, it is of course a very different environment. For one thing, you do not have a medical specialist, such as a GP, at the very least, and for another, there is the issue of access to records. Would you have any fears and concerns if we were to look at how the role of practice nurses within a community pharmacy environment might operate? Do you see any major difficulties, pitfalls or concerns? Is access to medical records a prerequisite for being able to expand that role and so on?

[32] **Ms Thomas:** Access to medical records would be essential. We have a couple of models of nurse-led primary care services in Wales. There is one just outside Pontypool, under the Aneurin Bevan Local Health Board, in which a particular nurse works slightly away from the geographical situation of five surgeries, so that, rather than the patients travelling to each of those five surgeries, she provides a more local service. She is linked in to each of those five surgeries. She has a prescription pad and is able to prescribe safely, even though it is quite a complicated system to ensure patient safety through the availability of information. So, there are examples that may be useful to look at when you consider remote access to patient information. However, that would be a prerequisite, certainly for a nurse, as a health professional with advanced training, working without a medical practitioner on site in making clinical decisions.

[33] **Ms Turnbull:** On that point, it is important to know what we are designing the service to deliver. All regulated health professionals have a responsibility to the regulator and to themselves to work within the limits of their competence. You would require a different skill set for the different services that you are trying to deliver. If you were trying to deliver sexual health services, for example, or chronic conditions management, you do not necessarily need a medical doctor to be present. In very much the same way as a GP would

refer on to colleagues in a particular specialty, in a situation where somebody comes to your service and you think, 'This is not something that we are designed to deliver', you would obviously refer that person on. There would be those kinds of protocols and systems in place, just as there are now in an accident and emergency department or a GP's surgery or wherever. You would need to consider those kinds of situations.

[34] **William Graham:** In your paper, you say that the RCN supports the development of enhanced or advanced services—you make your point there. You also note that there are only 213 independent prescribers in Wales for some 700 pharmacies. Could you give us an idea of how many nurse prescribers there are and whether you think that that could be a complementary service, particularly having regard to your previous answers?

[35] **Ms Thomas:** The last figure that I am aware of in respect of the number of nurse prescribers is around 400. I believe that that is last year's figure—I do not have the up-to-date figure for the tail end of this year. So, there is quite a number. One of the biggest concerns is that that resource is not being harnessed and that, despite money having been spent on the education programmes, the service itself has not thought enough about how it is going to fit in to meeting patient need in ways that are supported within the organisations. So, there is an untapped resource. Of course, the fear is that, as time goes along and as those skills are not being used, confidence wanes and people become deskilled. At the moment, that is the sort of figure that we are talking about. Some are in GP settings, where they are probably more able to use their skills, because of the support networks and systems in place. It is difficult to understand how many nurses are working in the hospital sector, because it is more difficult to identify who has actually written a prescription for that. I guess you are not so concerned about that particular area of the health service. So, in primary care there is a smallish number and it tends to be that those nurses have identified a professional interest. Before they are accepted onto a course, they have to demonstrate that there is a patient need that can be met, so that the investment in that training will be rewarded by patients having benefit from that. However, as Lisa pointed out earlier, it depends on a supportive employer—it is a requirement that there is a medical mentor in place to see them through that training. Therefore, it tends to be ad hoc and not so structured.

[36] **William Graham:** I do not mean to lead you, but would you say, therefore, that the role of the prescribing nurse is well demonstrated in rural areas and in following a care plan where there are substantial changes—perhaps needing a new medication—rather than relying on the static pharmacy?

[37] **Ms Turnbull:** There is a wealth of evidence, especially if you look to England, where independent non-medical prescribing was introduced a lot earlier than it was in Wales. There is a wealth of evidence demonstrating the benefits for the patient. Obviously, from their perspective, it can be easier and more convenient because they do not have to make a separate journey or a separate trip. It goes back to my point about depending on what service you are trying to deliver. If we are talking about a nurse who is a specialist in a particular field, you are obviously getting a specialist expert in that field. That can be beneficial in terms of what is prescribed and cost-effective in terms of the system as a whole. So, there is a wealth of evidence demonstrating that, where it is strategically thought through and, as Sue said, where the patient need has been established, the system works extremely well.

[38] **Ms Thomas:** There is also some evidence from the Scottish NHS, particularly on your question about rural health, as we have similar geographical considerations. It found the model of nurse independent prescribers to be useful when you consider how far an individual health professional would have to travel to meet a person. The idea is not to make more than one person have to go there—let the patient get their medication prescribed by that person, rather than have to go back to a surgery to ask somebody else to visit. So, you could look to the Scottish NHS for some evaluation of nurse prescribing in rural areas.

[39] **William Graham:** Could we obtain that evidence from Scotland?

[40] **Mark Drakeford:** Yes; we will have the chance to speak directly to some people from Scotland next week, and we can make sure that we take up that point with them.

[41] **Kirsty Williams:** I am not exactly clear what the message from the RCN is about the role of community pharmacies, and whether that could be expanded. Your paper said that you believe that the contribution is substantial, but then does not go on to explain what that service looks like from your perspective. What concerns me in what I am hearing this morning is that the change in the pharmacy contract has not led to a development of the services as envisaged. We were seven years behind England in finally getting around to changing the rules about nurse prescribing—how many years ago was that?

[42] **Ms Turnbull:** It was 2001.

[43] **Kirsty Williams:** Ten years down the line we have an ad hoc, non-strategic, unplanned situation whereby nurses are being trained, but are not then able to utilise those skills in assisting with patient care. What is it about the NHS in Wales over the last 10 years that has led to this situation? We had this vision of pharmacies doing more and nurses doing more, with the idea that that would free up doctors to do things that only doctors can, which would improve patient access. What is it that has stopped that from happening, from nurses' perspectives? Are there any lessons from your experience that we could read across on why the role of pharmacy has not developed over the last 10 years? What do we need to recommend that the Minister should change, so that nurses are being trained and those who have been trained, who have been invested in, can utilise those skills for the benefit of patients?

[44] **Ms Turnbull:** The key message from the Royal College of Nursing in Wales is that we have been saying for a long time that there needs to be better access to primary care in Wales. There are specific areas—sexual health is a good example—where we know that more services need to be provided. We know that our members feel that that is a huge concern, particularly in north Wales, where the current system is not delivering the services that we need. We also know that there are some geographical areas where access needs to be provided, where perhaps there is an insufficient number of GPs. There are also certain demographics with particular needs. We should not lose sight of the fact that this is not merely a response to consumer demand, but strategic, because we feel that if you provide care at the right time, and manage conditions in the right way, you will be preventing the illnesses becoming more acute and costing more at a later stage. There are sound reasons for doing that, apart from merely responding to consumer demand.

[45] Having said that, we are saying that nurses are in a position to assist in this process. You can use salaried nurses, nurses employed by GPs or nurses employed by pharmacists to assist in this process. That is our key message. In terms of what needs to be done, the reorganisation of the NHS in the previous Assembly provides an excellent opportunity in the sense that you now have a health board that is responsible for providing an integrated strategic approach in that area to primary care, community care and acute care. That is the opportunity, but in order for that to be taken up, perhaps we need a national direction, and to look at where innovative best practice has worked well. I think that I am right in saying that the Rhondda Cynon Taf area would be an example of that, but we perhaps need to ask why, if it has worked well there, other health boards are not doing the same thing. There needs to be clearer national direction to try to get some kind of consistency. Sometimes it is dependent on the personalities and the historical approach of the individuals, who may always have looked at primary care in a certain way in their area, and perhaps are not as open to innovation or learning the lessons as others. If it is left to individual committees and individual areas, you

will get that kind of inconsistency in approach.

10.00 a.m.

[46] **Kirsty Williams:** I would just like to follow that up. You said that there are not really examples of nurses working directly with pharmacists. Is there a role, for example, for district nurses, who go into the houses of patients who are often quite elderly and who often have complex medication regimes? Are there no examples of the community district nursing service working with local pharmacies with regard to medicine management and compliance issues for elderly people in their homes, because they can have quite complex medication needs? There are also nurses working in the residential care sector. Are there any examples of projects where nurses working in residential care settings work with pharmacies to ensure that the medication regimes of those in the residential care home are reviewed and managed, and to ensure compliance? We are very focused on nurses being in GP practices, but nurses work in people's homes, nurses are running care homes and providing care within a residential setting for our most vulnerable citizens. There have been controversies, have there not, about medication in such settings? Is there a role there for better working between the nursing profession and pharmacies?

[47] **Ms Thomas:** Would it help if I painted a picture of what one of these nurses might look like? I am always afraid that when we hear the term 'nurse prescriber', we imagine a nurse holding on to her prescription pad, but that is not always the case. It might be that they have access to a prescription pad, but a district nurse working in someone's home might realise that someone is taking several medicines and, with the knowledge and skills developed through education, that nurse may be able to make a judgment as to how safe it is for that person to be using all of those medicines. It may also be about something that seems very simple: the nurse will be able to ensure that that person knows how and when to take that medicine correctly, the implications of taking the medicine, or not, and who to turn to for advice if they have concerns that may be related to their medicine. That is the area that we know as 'patient concordance' with taking the medicine that has been prescribed. If one assumes that a medicine has been prescribed by the prescriber in that patient's best interests, you want to be sure that the money that is spent on that medicine is well spent, but, most importantly, you want to check that the patient is safe in using the medicine.

[48] So, there is an opportunity for medication reviews, which I know is one of the features of the new pharmacy contract, in a slightly different way. However, as has been pointed out, if a nurse is going to prescribe a medicine, they have to know about every other medicine that the patient is taking, because they have to know that it is safe to add that medicine into that cocktail. So, it is a very important role and it is one that hinges on being able to spend time with the patient, which is what nurses are known for. It needs to be thought through and there needs to be caution, which research has shown nurses to be known for. In all the time that nurses have been prescribing, there has not, to my knowledge, been one single adverse event or complaint made about nurses prescribing. So, they are safe.

[49] The role is as much about offering support as holding on to a prescription pad and wanting to add yet another medicine. Nurses are taught how to assess whether to prescribe. Being able to prescribe does not mean that they will prescribe. It is about making a professional judgment about what is best for that patient. So, it is a point that is really well made and I am glad that it has been made, that wherever a patient lives or seeks health support or care, there is an opportunity for that patient to be managed safely and nurses can contribute to that.

[50] **William Graham:** I would like to raise a point for clarity. The scenario is that the person is at home and, as you describe, the nurse would simply write the prescription and presumably drop it off at the pharmacy and, in the way in which these things are now done, it

would be delivered. So, there would be a very simple solution.

[51] **Ms Thomas:** In terms of expediency, absolutely, but at the same time that nurse, who is invariably the person who sees inside the cupboard where there is a big stockpile of medicines, can be part of the overall management of medicines, such as safe disposal. There are very simple ways of contributing to the health picture.

[52] **Vaughan Gething:** It has been very interesting so far on a number of points, but I want to go back to one of the points that you mentioned but did not go on to develop, namely the point about minor ailments. We have heard some differing views on this, particularly the fact that a number of people have said that there is potential for a minor ailments scheme to be useful by using community pharmacy, but I am interested to hear your views about what level of use that would have, not only in terms of people accessing healthcare, but whether there would be a cost saving or a cost increase in rolling out a minor ailments scheme. What would that best look like using community pharmacy?

[53] **Ms Turnbull:** A question would first need to be asked about the benefits required and the needs of that area in these days of very limited investment. For example, you could look at an area and decide that a chronic condition-focused service would be more effective than a minor ailments service. You would have to answer that question first. In terms of where minor ailments services have been run, they have been effective in the sense that patients have been satisfied, have had a good experience, have not been referred elsewhere and the outcome has been good, so there was clinical effectiveness. There is evidence to show that those services work where they operate, but the answer to the question as to whether you should focus on minor ailments rather than anything else would depend on the locality. You would have to balance the decision against all of the other needs as to what you would address first.

[54] **Ms Thomas:** Some education programmes on minor illness causes were in place for nurses when I worked as a senior lecturer in higher education. An interesting question to begin with is how one assesses whether a presenting complaint is that of a minor illness or something that is not so minor. You want to be sure that a system is in place that ensures a safe approach to patient assessment by someone who is appropriately qualified.

[55] To reinforce the point that Lisa made, we need to establish what health needs are best met through different models. Minor ailments can usually be self-managed by the patient with medicines that are obtainable over the counter when there is a pharmacist available from whom to obtain advice. Therefore, what would a new service propose to do that is different from what is already in place, and how does that sit alongside other priorities for meeting health needs? Chronic conditions seem to be the area that causes people long-term problems and that might be imaginatively dealt with. So, it is important to go right back to basics and look at what the health need is.

[56] **Vaughan Gething:** One of the concerns put to us by GPs when they gave evidence was that expanding the role of community pharmacy could potentially lead to an increase in cost because of services being duplicated and/or fragmented. They gave an interesting example in their written evidence of the worried-well cruising around each month having a different cholesterol test in different pharmacies. If that expansion in community pharmacy provision were to happen, would there be a real risk that that fragmentation or duplication of services would happen, or do you have evidence that points to how it has been managed successfully and unsuccessfully? Are there pitfalls that we should be looking to avoid?

[57] **Ms Turnbull:** We will look to see if we can come back with additional evidence. However, the Royal College of Nursing in Wales has been concerned for a long time about access to primary care. As a general rule, it would not like to accept the premise that the

population is feckless or making choices simply for convenience. If people are making choices about what service they are looking for, they are making those choices because they need to. If you cannot get in to see your GP for a number of weeks, or you are told that you can see them the following day but will have to turn up at 8 a.m. and wait for an unspecified number of hours—which is difficult if you are working or have caring responsibilities—at that point you are likely to seek healthcare elsewhere or not seek it at all. We know that some segments of the population are not accessing healthcare, and that is quite worrying.

[58] You should start from the approach that you need to design the healthcare system around need. It is not a question of meeting consumer demand for the sake of it; it is about trying to meet the needs of the population. While the needs of the vast majority of the population are served extremely well by the GP system, we know that there are some that are not. That is where you have to come up with alternative models. There is evidence on this. Sexual health and chronic conditions are good examples. There are areas in England where, through the walk-in centre model, there has been a good, unintended policy consequence. Those centres may have been built for a particular reason, but have, in fact, answered a different need. In deprived areas, those centres have worked incredibly well in providing healthcare to that population. So, there are models for how that can be done. Yes, there is a risk. When you are designing any new system or looking at a new policy there is always a risk that it could be delivered badly or fragmented. However, you should not respond to that risk by deciding not to do anything, because the problem that you needed to solve still exists. Our response would be: there is a risk, of course, and we need to assess it reasonably, and consider what can be done to minimise or reduce it. It is not insurmountable.

[59] **Vaughan Gething:** A number of times today you have mentioned evidence that has emerged from other models of primary care in England and how they work, and you have mentioned that in favourable terms. It would be helpful to have those direct examples pointed out to us when we are considering what to recommend. If there are models that work already, then we do not need to reinvent the wheel in Wales.

[60] I appreciate what you said earlier about access to medical records being a potential barrier to expansion. One of the themes that has emerged in this inquiry is barriers to the expansion of community pharmacy and why it is not delivering more under the new contract. Some people say that it is partly to do with the contract, but a lot of it appears to be to do with the inability of different professional groups, for whatever reason, to work together to deliver expansion. Do you have a perspective as to why that has been the case? What is your view on where the appropriate leadership for that would be, in terms of finding a resolution? Is it at a national level in the Assembly, at the health board level, or is it simply that local primary care teams, and the different people involved in them, need to work together?

[61] **Ms Thomas:** I do not have an absolute answer. The health service is such a complicated organisation. I am learning more about the complicated area that is the world of pharmacy through the programme boards that I sit on, with the different sorts of people who contribute from the world of pharmacy—people from different organisations as well as individual practitioners, who are independent contractors. There is a lot in there that would contribute to understanding roles, responsibilities, contributions and motives. Different initiatives are put in place and sometimes it is not clear whether it is patient need that is being addressed or financial imperatives from the business side of pharmacy—that is the reality of the world of pharmacy.

10.15 a.m.

[62] From a nursing point of view, there is a lot to do with culture, change and traditional ways of working that are tested, and your point about leadership is a key one. Introducing change, and informing everyone about how that change will be supported and how it will

benefit patients, needs to be done very carefully, with a consistent voice across each professional group—through service planners and through policy leaders. The nurse prescribers have certainly felt that opportunities to sit down to agree how that is going to be done have been lacking in terms of support for their changing roles. So, I guess that there must be parallels there within community pharmacy.

[63] **Ms Turnbull:** One of the key issues in designing policy or a service, at health board level and at national level, is that you get views from all health professionals involved in designing these. What happens if any one profession dominates is that—not for any reason of conspiracy but simply because they come from the same background or have the same culture or perceptions—it will instinctively design something from its perspective. You have to work quite hard to try to get a variety of voices around the table, including the voice of the user—that has to be heard as well. The solution to that problem is a stronger national direction, and, perhaps, a stronger national direction on the inclusion of all health professionals and user voices. Very often, if you look at the senior committees that are put together, you do not see that, and that becomes a problem later on, because then you get what looks like resistance. It might actually be someone trying to make a useful point. So that is a potential way forward.

[64] To give you a positive, very recent example of this, we now have an informatics board, looking at the development of informatics in the community. That is extremely recent, because, until very recently, the focus had been entirely on other sectors. Part of that is very much about nursing and other professions trying to say that we need to focus on them. They are not saying, ‘Focus on us because we want you to focus on us’; they are saying this because the patient is not benefiting, because the patient is in the middle of this and may very well be resident in a care home, or in the community dependent on support from the district nursing team, or not in the primary care system but occasionally making a visit to a community pharmacy for advice. So, we have to address the patient where the patient is, rather than saying that we wish the patient would be where it is most convenient for us. That is important.

[65] **Ms Thomas:** The board that Lisa referred to is the community informatics programme board, which is chaired by one of the nurse directors, Carol Shillabeer. The board met for the first time last week. It addresses many of the questions that were raised earlier about how people working in disparate and remote situations can still link into the system so that patient information and knowledge can be accessed by whoever needs to access it, wherever they are working.

[66] **Mark Drakeford:** That is useful, thank you very much. I am keen that we should squeeze in Elin’s questions before we close the session.

[67] **Elin Jones:** I have two questions, one of which is specifically on the seasonal flu jab. We know that there are some groups of people that should be accessing the seasonal flu jab where take-up is lower, particularly the under-65 at-risk groups. We have had differing evidence from various interested parties on whether the community pharmacy is an appropriate place for administering the flu jab. Given that, I guess, most flu jabs are administered by nurses, mainly in GP practices, do you have a view on the administration of flu jabs in community pharmacy settings, either by community pharmacists or by nurses in that setting? Finally, on the issue you just touched on of informatics and the development of greater access to patient information in different settings and by different healthcare professionals, we have also had differing evidence on access to patient records and whether those should be made more available, perhaps in community pharmacy settings. We have had some resistance to that. We had interesting evidence last week saying that most patients expect that various healthcare professionals would automatically know their patient records. They do not expect the patient record to be kept solely for the use of the GP; they think that it is also available in hospital or community healthcare settings. I am interested in whether you

have views on how widely patient records and information should be shared with different interested parties.

[68] **Ms Thomas:** The model that has been tested in Aneurin Bevan Local Health Board is of opening up access to parts of the GP record to, I believe, the out-of-hours service. I believe that the evaluation of that was good, and that there has been a level of satisfaction with the information viewed—by those who do not work in the GP surgery as well as by the GPs who are sharing part of the record that has traditionally been held by their service. That could be considered. If the record can be opened up safely and successfully to one extra service, why should that not be done for other services elsewhere? The community informatics programme board will look at those sorts of models. At the moment, it has spent a lot of time looking at the myriad systems available in different services across the health sector. The district nursing service across Wales will use a different system, as will each of the health boards, and the systems are different again to those used by social services, GPs' surgeries and pharmacies, which tend not to have a link into the system anyway. So, the board will start to get a sense of what is going on and of the scope of things, before it can start to make sense of it and to pull things together, looking at the most sensible way of doing that. The key to doing that is getting the IT right, to have safe sharing of information.

[69] You also asked about flu jabs. Again, what you have put forward is, first of all, is a problem, and then the issue is how best to address it and what is the right way of doing that. Why would you want to increase the availability of the flu jab to people? If there is a good reason for having increased ways of people getting hold of an essential part of healthcare, especially those who are vulnerable, then that is fine, provided that the information systems are available to link into. You do not want to be a position where someone would receive something twice, for example. You would have to ensure that safety is built-in. However, patient need has to be paramount and, in that case, different models should be explored, in my view.

[70] **Mark Drakeford:** Thank you very much. That has all been very useful for us in this inquiry. Thank you for giving us your time this morning. As you know, you will be sent a transcript. If there is anything that we have not asked you or any last point that you think that we really ought to take away, you have a minute to highlight that. However, if you think that we have managed to pick up all the main points, we can leave it at that.

[71] **Ms Turnbull:** Thank you. We will endeavour to do a literature search for you and come back with some references.

[72] **Mark Drakeford:** Excellent. Thank you both very much indeed. The rest of us will have a five-minute break. Our representative from the Family Planning Association is possibly in Cardiff or possibly still on a train somewhere between here and north Wales. We will know by 10.30 a.m. If she has not arrived, we will start in any case with the Diabetes UK Cymru representative and hope that leaves on the line will allow her to get here later on.

*Gohiriwyd y cyfarfod rhwng 10.24 a.m. a 10.33 a.m.
The meeting adjourned between 10.24 a.m. and 10.33 a.m.*

**Ymchwiliad i'r Cyfraniad a Wneir gan Fferyllfeydd Cymunedol i
Wasanaethau Iechyd yng Nghymru: Tystiolaeth gan Diabetes UK Cymru a'r
Gymdeithas Cynllunio Teulu**

**Inquiry into the Contribution of Community Pharmacy to Health Services in
Wales: Evidence from Diabetes UK Cymru and the Family Planning
Association**

[73] **Mark Drakeford:** Croeso i Jason Harding, rheolwr polisi a materion cyhoeddus Diabetes UK Cymru, a Melanie Gadd, sydd wedi dod o'r gogledd y bore yma ar y trê. Mae Melanie yn gydlynnydd prosiect ar gyfer prosiect Jiwsy y Gymdeithas Cynllunio Teulu. Byddaf yn gofyn i'r ddau ohonoch gymryd munud neu ddau i dynnu ein sylw at unrhyw beth pwysig yn y papurau yr ydym wedi'u derbyn—a diolch am y papurau hynny. Ar ôl hynny, byddaf yn troi at aelodau'r pwyllgor a fydd yn holi cwestiynau.

Mark Drakeford: I welcome Jason Harding, policy and public affairs manager for Diabetes UK Cymru, and Melanie Gadd, who has come from north Wales this morning on the train. Melanie is the project co-ordinator for the Family Planning Association's Jiwsy project. I will ask you both to take a minute or two to draw our attention to anything of importance in the papers that we have received—thank you for those papers. After that, I will turn to committee members, who will ask questions.

[74] If there are any brief opening remarks that you would like to make, please do so, and then we will get on with some questions. Melanie, do you want to say anything first?

[75] **Ms Gadd:** Yes. My name is Melanie Gadd and I co-ordinate a sexual health project in north Wales, working with vulnerable young people. FPA has a long history of working in the sexual health field, both in Wales and in the rest of the UK. The points that we would particularly like to make in terms of community pharmacy include the importance for people of all ages, but especially young people, to be able to access emergency hormonal contraception through their community pharmacy. Advanced prescribing of EHC has been shown to be greatly reassuring to women who are worried about their contraceptive method failing, especially young women who live in areas where it is difficult to access EHC, because of rurality or other access issues—it can be of great comfort to them. Also, it would be interesting to see community pharmacies getting involved in C-card schemes as future distribution points.

[76] **Mr Harding:** Good morning, everybody. I am Jason Harding, policy lead for Diabetes UK Cymru. The main reason that we are here today is, on the one side, to give you an indication of what is going on in relation to diabetes in Wales currently and some of the implications for the NHS, particularly with regard to how pharmacy could play a role in meeting some of the challenges that we have identified as being likely to arise, and, on the other side, because we undertook six months ago quite an intensive and sophisticated piece of operational work with Community Pharmacy Wales, the Royal Pharmaceutical Society, Public Health Wales and the seven health boards in Wales. So, we have a good understanding of how to deliver a cross-coalition piece of work, particularly in relation to Diabetes UK Cymru utilising our pharmacy colleagues.

[77] **Mark Drakeford:** I am keen to get as many questions in as we can in the three quarters of an hour that we have. I appeal to Members: please make your questions as focused as you can. William, I see that you are ready.

[78] **William Graham:** Could I ask for your views on the importance of joint working, not just with pharmacies, but with the NHS and third sector providers, too? What are your views on that?

[79] **Ms Gadd:** For us, it is invaluable. As a charity, we get involved in as much joint working as possible, because it really spreads the load and shares the expertise between different people. I think that 86 per cent of Anglesey's pharmacies have signed up to the enhanced contracts to deliver EHC, and the family planning service up there has said that its prescribing of EHC has gone down massively because of that. So, they are working hand-in-hand, and we in the third sector really welcome joint working.

[80] **Mr Harding:** In relation to the initiative that we undertook, it would not have been delivered without the agreement, partnership and support of all the different sectors. So, you have public health, the health boards and engagement via the community pharmacy contract with the local pharmacists. Diabetes UK provides expertise in relation to the particular health condition that was being addressed, and you have Community Pharmacy Wales and the Royal Pharmaceutical Society providing the gel to deliver the project.

[81] Operationally, it could not have been delivered without it, and you would not have had the joined-up work between the pharmacy and the GPs, or the health boards understanding how that related to the local communities in their area, so it should absolutely be encouraged. I do not think that we could have delivered the same impact without having each of those partners in place. I would not try to do it again without a similar range of partnership and co-operation.

[82] **William Graham:** We heard in evidence from the RCN—almost as an aside—that, if we substituted walk-in centres for pharmacies, particularly in deprived areas, and extended opening hours, it would have a good effect on contraception and so on. Would you think that that would be a good role for the pharmacies?

[83] **Ms Gadd:** Absolutely. The great thing about having EHC distributed from pharmacies is that there is no stigma attached to a person who walks in to a pharmacy—he or she can be there for any reason. Extended opening hours would benefit people who are at school, in education, in work or those who have childcare issues. So, the more stuff that is available, the better; it has to be a good thing.

[84] **Mr Harding:** I am particularly interested in one point, which I think is a useful thing to consider, namely that different people have different levels of health literacy. Some people are up to speed on their health and what they need to do to take care of themselves, but the vast majority of people across the country are not in that position. I see the opportunity to provide easy access to non-threatening and non-authority health professionals as a real benefit. In a range of communities, and for particular sub-groups within those communities—particularly males, for example—pharmacies are much more accessible and easy places to start the process of engagement with health professionals, in which I am particularly interested. So, there is a particular role that could be delivered there.

[85] **Kirsty Williams:** My first question is to Diabetes UK. The risk-awareness screening programme that ran last year was very successful. I went along to my own pharmacy to see the work that it had been doing. I suppose that it is difficult to know more about the people who were identified as high risk and referred to GPs. Is there any way of following that up? Is there any way of knowing whether those people who were advised by their pharmacist of being at high risk attended their GP surgery, and was there a diagnosis as a result of that attendance?

[86] My second question is to the FPA. I congratulate the FPA on the amazing work that it does across the UK and here in Wales, especially on behalf of young people. We have heard much about services being patchy, and that sometimes it is difficult to get all pharmacies involved in particular projects. That is one of the reasons why we have not seen the

development of some services. You talked about the number of pharmacies in Anglesey that are participating in the EHC scheme. Could you give us figures from across Wales? How many of those pharmacies are involved in advanced prescribing of emergency contraception? How many services are available, and are they consistently available across Wales?

[87] **Mr Harding:** For this particular initiative, because of its logistical size, we were unable to do the follow-up work. If someone was assessed as high risk—with anticipation that one in three would develop diabetes within the next 10 years—they were provided with a letter to take to their GP. We do not have any data that show how many people followed that through or the diagnosis from that particular initiative. What I can say is that we also do a range of roadshows—a similar initiative, but delivered purely by Diabetes UK—where health professionals visit a particular locality for a day or two to carry out risk assessments. We have the data from those, to give you an indication. Around 20 to 30 per cent of people who come along to our roadshow stands are referred to their GP because they are classed as high risk. Approximately one in five of those people are diagnosed with diabetes. Interestingly, even if those classified as high risk when they go along to have a diabetes check are not diagnosed with diabetes, they usually have issues in relation to lifestyle and diet with which the health professional can help them. So, there is an attempt to stop that progress.

[88] **Ms Gadd:** I can only give you the figure for Ynys Môn, because I was provided with that figure last week. I can find out who else is providing the enhanced service in Wales. We are currently doing a mapping exercise for Gwynedd, so I do not have those figures at the moment. As far as I am aware, no-one is doing advanced prescribing at the moment. You can buy emergency hormonal contraception from pharmacies, but you cannot go in and get it for free. As far as I am aware, there is no detail on that at the moment.

[89] **Kirsty Williams:** Should this committee recommend that EHC be prescribed in advance, without people being charged for it?

[90] **Ms Gadd:** Yes. Anything that prevents an unintended pregnancy would be a good thing. If somebody was using condoms as their main method of contraception, having some EHC in their washbag or medicine cabinet in case of condom failure would be helpful.

10.45 a.m.

[91] **Rebecca Evans:** My questions are for Diabetes UK. We have heard from the BMA that, in its experience, screening does not always attract the target audience that you are looking to help, because they might be the people who are least likely to take advantage of the scheme. What are your views on that and on whether pharmacies offering risk assessments and screening is an effective use of resources?

[92] **Mr Harding:** My view is that, yes, it is. I agree that there are difficulties in reaching hard-to-reach groups in society, and screening and risk assessment, if delivered effectively—and there are various marketing techniques and abilities, such as partnering with local partners within communities, which understand their communities more effectively than I would at a national level—means that good work can be done in those areas. Pharmacies can play an interesting and important role in the early stage of risk assessment; risk assessment and screening is a pathway to diagnosis within a health centre or for a GP.

[93] As I have stated in some of the information that I have provided to the committee, the geographical position of pharmacies, and the way that people view health professionals in pharmacies, is less intimidating than making an appointment with a GP or a nurse. More people are likely to do that initial engagement at a local pharmacy. So, if a system can be constructed whereby that initial quick screening or risk assessment is provided, with the right judgment as to when that is referred on for diagnosis by a GP, then that would be a more

effective approach. That is my experience of delivering this initiative and from roadshow work that we do.

[94] **Rebecca Evans:** In a previous paper, we learned that participation in the diabetes project was particularly low in Pembrokeshire and Ceredigion. What is the explanation for that and are there particular kinds of pharmacies that are more likely to participate? Are there ways in which we could encourage more to participate in future?

[95] **Mr Harding:** This initiative was delivered via the community pharmacy contract, so every pharmacy should have taken the information and delivered on that initiative. The report that was provided to the committee, I presume from CPW or the Royal Pharmaceutical Society, showed that 75 per cent of pharmacies responded with an evaluation of their work within this initiative. One can imagine that some did the work, but did not respond. The information was provided to the pharmacies and communications occurred via the local health boards and the chief pharmacists. So, if some pharmacies did not take part, I do not know why that was the case. Those pharmacies should have followed their obligations, because they are obliged and paid to do that.

[96] **Lindsay Whittle:** This question may be more relevant to you, Melanie, but Jason can also contribute if he so wishes. We heard in previous evidence from some people that pharmacies and community pharmacies are no more than glorified corner shops. That is not a statement that I agree with at all, but, nevertheless, we must recognise that, by appearance, they are corner shops. Is there any evidence that young people in particular are put off from seeking advice or emergency contraception, for example, from pharmacists because of the confidentiality issues? In some communities in Wales, everyone is related to each other—some Valleys communities are called ‘the land of twitching curtains’. So, we have particular issues with young people being put off. When we spoke to pharmacists, they told us that about 150 or so pharmacies did not have a room where people could speak to the pharmacist in private. Should we insist upon pharmacies having those rooms, because it is putting young people off?

[97] **Ms Gadd:** Young people have the same sort of concerns about confidentiality all over Wales. I do not have any answers to the question regarding evidence of whether it puts people off or not, because we have done no research into that area. I have always assumed that if you were doing the advanced contract for emergency hormonal contraception, you had to have a private consultation area. The pharmacies that I have been in have had a private area to do that, so it would be possible to have a confidential discussion with the pharmacist. The thing about going into a pharmacy is that you could be going in there for any reason. This takes a lot of the stigma away. It is not like being seen walking into a clinic or a GP surgery, and then being asked why afterwards. This is about the normality of a pharmacy’s status as a corner shop that supplies all sorts of everyday things. A young woman could be as likely to go in there to get her tampons as to receive EHC, and she could come up with a good excuse for why she was there, or no-one would bother to think about questioning her. Regarding my experience of working with young people, quite a few young people have told me that they have been to pharmacies to get emergency contraception and that they have never reported any problems with it.

[98] **Lindsay Whittle:** In respect of Jason, I am not sure whether this issue is relevant to diabetes, but you never know.

[99] **Mr Harding:** I would echo what Melanie said. We would acknowledge that, across the portfolio of pharmacy services in Wales, this is not a generic model where everyone looks exactly the same. There are some that are very professional, large, well-resourced outfits—mainly commercial chains. Then, there are some outfits that are very local.

[100] The first point that I would make is that, for certain types of low-level health information, it is useful to have a local amenity like a pharmacy that does a range of different things. As I have said, the idea of being able to access that really easily, without feeling as though there are any medical barriers that would put you off, is a useful thing in certain circumstances. The other point that I would make is, if you look at the whole portfolio of approximately 706, or 708, community pharmacies in Wales, you will see that the decision to decide on what to provide, based on the lowest common denominator or weakest link within that particular set-up, is probably not the most sophisticated approach. There will be some pharmacies that are able to deliver a much more sophisticated and fulsome range of duties and others that cannot. Part of the thinking in this process would be to acknowledge the diversity within this family.

[101] **Lindsay Whittle:** Thank you for that. I would like to say briefly that I am extremely uncomfortable that community pharmacies could be offering this advice over the counter, in front of other people. I think that it is absolutely vital that if we are to press for these issues, and I hope that we are going to, we must insist that a confidential room is available. That is absolutely vital. If there is no such room available, I fear that we will be putting people off using what is going to be a very good service.

[102] **Mark Drakeford:** I will now bring in Mick, followed by Vaughan.

[103] **Mick Antoniwi:** I have some concerns here, and I will aim my questions at you, Melanie. How do you see the role of community pharmacies, particularly in the area of family planning? There are all sorts of educational issues here. There are young people involved, who are often vulnerable, and complex issues arise. Do you see community pharmacies essentially as pointers to more specialist advice and services, rather than as providers? Should there be defined limits as to what you would expect a community pharmacy to do, and do you see any dangers in stepping beyond those limits?

[104] **Ms Gadd:** Yes, definitely. If pharmacies were to provide more sexual health services to people in the community, they would very much need to work hand in hand with all of the other excellent sexual health services that are out there in Wales. We cannot expect the staff who work in pharmacies to be experts in all things. So, the ability to signpost the good-quality services that are out there would be the most important thing. Pharmacists should work in partnership with these service providers. They would obviously need to have some level of training to enable them to signpost effectively. However, they should always be able to encourage people to seek the healthcare that they need.

[105] **Mick Antoniwi:** Do you see a danger of confusion regarding what the pathway is? People might think or expect that pharmacies are capable of doing one thing, as opposed to another. What are the dangers in that context?

[106] **Ms Gadd:** I do not anticipate any danger if the training is of good quality and people are clued-up regarding where they should be signposting people. Many pharmacies are already delivering enhanced services for emergency hormonal contraception. They would have to signpost people to sexual health services if a contraception method has failed or has not been used, which resulted in the person needing EHC. The good practice should be that people are signposted to contraceptive services or their GP to get their contraception sorted out in the long term. That should be happening anyway. People should also be signposted to genito-urinary medicine services, because if they have had unprotected sexual contact they could be in danger of a sexually transmitted infection. I assume that that is working well at the moment. No problems have been reported. However, I must admit that I do not have the expertise to say whether that is definitely happening.

[107] **Vaughan Gething:** Going back to the diabetes public health campaign and the trial—

linking with another theme that we have been discussing, namely access to medical records—you said that people who are identified as being at risk are given a letter to take to their GP. That raises issues about the level of compliance from the patient, regarding whether they are going to take that letter to their GP. This takes us back to the point about access to medical records. Do you think a community pharmacy should have access to medical records? People could pretend that they do not need to take a letter to their GP, if it goes on the record.

[108] **Mr Harding:** I do not have a clear view on that. Doctors' representatives—the British Medical Association, GPs and so on—will have a particular position on that, as will pharmacies. The requirement would be to enable both of those bodies, as two competing power blocks, to reach an agreement that acknowledges that there are strengths to both of their positions. My own objective perspective, from outside of those two different bodies—as I said in the submission—is that I see an increase and enhancement in the role of pharmacies as useful. Where that line would be drawn—between initial engagement, risk assessment, screening, basic provision of information on diet and lifestyle, basic advice in relation to self-management of diabetes, referral pathways to GP centres or more specialised support if it is required—would need to be negotiated between those two sets of professional bodies. I have my own view on a more healthy direction that it could go in, but the technical details would need to be decided between those two professional bodies, and they would be competing to stake their claim on the ground.

[109] **Vaughan Gething:** That is interesting because, as Elin Jones mentioned earlier, the only representative voice that we have heard from patients was clear that there is an expectation among users of the health service that shared access already exists. So, the most important people already think that the access is available.

[110] My next point is on barriers, which is another consistent theme. From your experience in running this campaign with a range of different people, what level of co-operation and co-ordination was there? We know that there was an uneven picture; Rebecca Evans has already mentioned the level of compliance from the pharmacies in taking part. From your experience, how did the different professional bodies and groups work together, or not, in your campaign? I am thinking of the health boards, GPs, pharmacies, and all the people in between.

[111] **Mr Harding:** It was a five-month project, and it would not have happened unless Diabetes UK Wales had pushed for it. The charity did all of the project management and produced and paid for all of the materials. If Diabetes UK Wales was not a part of that coalition, then it would not have happened. There were issues in relation to the effectiveness of the efficacy of the initiative in relation to the delivery of different pharmacies. We were reliant on health boards and their communication channels, along with the chief pharmacist of each of the health boards, and the local pharmacists—the cascading model of delivering materials and persuading pharmacies who were the interface with the public to do that. We were reliant on that system working effectively. If we had a response from approximately 75 per cent of pharmacies that conducted the exercise and delivered an evaluation of their work and what they found, to me, that was a reasonable level of engagement. To increase that level of engagement to get 100 per cent, the focus would have to be at a health board level and at a locality pharmacy level, to ensure that stuff that is delivered through these key channels is actually acted upon.

11.00 a.m.

[112] **Vaughan Gething:** That brings me quite neatly to my third point, which is that, in this trial, one in four pharmacies not responding is actually quite a high incidence of a lack of compliance. If we were to recommend greater roll-out, something would have to be done to address how those pharmacies do and do not take part and on the leadership and practical

management. That brings us back to health boards, because the first point in the terms of reference is about the extent to which local health boards have taken advantage of the contract. I am interested in your view on the role of health boards in the campaign that you ran with them and whether you saw any variance between those health boards in the level to which they provided leadership, not only in getting this campaign off the ground, but with regard to how the campaign was then managed over the five-month period. I am also interested in variance between health boards at the end of the campaign, because it is not just a question of saying, 'Let's do this, and then away you go'. I am more interested in how you get to an end point and then evaluation of the role that health boards did or did not play in that. We have had some fairly clear evidence about a varying level of interest and leadership from those health boards. So, your practical experience of this would be interesting.

[113] **Mr Harding:** There are two things to say in response to that. First, the health boards received the finalised package at their depots in their localities a month before the exercise was due to appear, and their key responsibility was to deliver that physically to the pharmacies within their areas. There was no real input during the infancy of the project, to the production of materials and the checking of all of that. That was primarily conducted by Diabetes UK, CPW and the Royal Pharmaceutical Society, along with Public Health Wales. So, the role of the health boards was very much at the back end of the project, and it was primarily to deliver something that they had received.

[114] Secondly, on the differences in the level of buy-in in the various health boards, we relied on Public Health Wales to deliver that information through those channels and to communicate with those people. I know that the committee of the chief pharmacists is quite a fresh body, and the proposal to do this initiative was one of the first that that body had received at one of its first meetings. So, perhaps, to be fair to the pharmacists within the local health boards, this was one of the first initiatives they had to deliver co-operatively as a group of people. One would imagine that, in year two, after going through this six times for each of the campaigns, they would be in a much better place to deliver it more effectively in 2012, if they chose to do it.

[115] **Vaughan Gething:** That was interesting.

[116] **Mark Drakeford:** Melanie, is there anything you want to add on this one? It is an important point for us as a committee. On one hand, we have had evidence suggesting that we ought to propose to Government that community pharmacists can and should do more. On the other hand, we have had evidence on the variability in the sector, and questions are being asked about whether it is really capable of taking on more duties right across Wales, reliably and everywhere. Emergency hormonal contraception is one of the very few things that all pharmacists are meant to be offering. In your experience, has that issue of variability been a factor? Is it something that they genuinely offer everywhere, or have some pharmacies or some parts of Wales been harder to bring online than others?

[117] **Ms Gadd:** I must admit that I do not have the expertise to answer that question. I can speak only about my personal experience in north Wales, where there were initial issues with rolling out the EHC programme, because the contract was for the pharmacist, not the building or the location. So, someone might go to a location because they thought that they could get EHC, but it might be that particular pharmacist's day off and there might be a locum who did not have the contract to deliver it. As far as I am aware, these issues are being ironed out. There is definitely less being said about it now, but I could find out about that for you if you like.

[118] **Mark Drakeford:** That would be very helpful to us. On that point specifically, we have also heard evidence about the changing nature of the sector. With more and more local outlets turning out to be part of a larger chain, the issue of there being a different pharmacist

every time you go there has become more of a concern. In the EHC example, where it was individual pharmacists who were being licensed to do it, have you, from your experience in north Wales, detected any difference between the old-fashioned, genuinely local one-person shop and a chain, where there may be different people behind the counter every time you go there?

[119] **Ms Gadd:** No. I do not know the answer to that, sorry.

[120] **Kirsty Williams:** I have been told outside the committee that there is an issue in that it is not only about individual pharmacists being the people who hold the qualification, but, in some cases, you have to have a licence for each local health board area that you would work in. So, for example, if you are a locum pharmacist who works sometimes in Cardiff, sometimes in the Valleys and sometimes in Newport, you would have to apply each time to each local health board to get the say-so to be able to do it. Can we look at that to see whether that is the case?

[121] **Mark Drakeford:** I think that we should. I have also heard that. People are being required to do the identical training all over again because the training that they had somewhere else in Wales was not portable.

[122] **Ms Gadd:** Also, sometimes, locum pharmacists come in from England. So, for example, if you have a chain of pharmacies and the pharmacist from Liverpool or Chester pops over the border to work as locum, they need to be able to transfer.

[123] **Kirsty Williams:** That is important for the entire community down the border.

[124] **Mark Drakeford:** Yes. We have a few minutes if anyone has any final question that they want to ask.

[125] **Rebecca Evans:** I want to pick up on Vaughan's question about information sharing across different people working in health, especially from an FPA point of view. I can imagine that there may be individuals going around different community pharmacies to get emergency contraception, and they might not come up on the radar as someone who may need extra information or support. Do you have a view on whether information should be shared across pharmacies?

[126] **Ms Gadd:** In sexual health services generally, sexual health records are separate from GP records anyway, so they kind of work in a bubble of dealing with what is presented in front of them in terms of sexual health history, not necessarily other medical history. With regard to someone going to see different pharmacists for different EHC, hopefully, good signposting and encouragement from pharmacists to access other services should take care of that. Ultimately, if it is someone's choice not to access the service, sharing records about them might not help. If it was brought up and they were told, 'This is the third time that you have had this; you must go to see someone next time', it might put them off going to see a pharmacist the next time; it might not, they might go to seek help, but it might put them off. Anything that we can do to enable people's access to what they need now and in the future will be a good thing.

[127] **Mark Drakeford:** Thank you for your evidence this morning. It has been very helpful for us to hear of some specific services that have been delivered via a community pharmacy network and to hear evidence from that perspective. We have a few minutes left. If there are any points that we have not covered in our questions that you think are important that we should take away from your experience, you have a chance to ensure that we do not end without hearing them.

[128] **Ms Gadd:** I would like to make a point about C-card schemes; I hope that everyone is familiar with them. They are schemes where a young person will go to a youth worker and receive an educational session about how to use condoms properly. They will get signed off as having shown that they understood all the information, they are Fraser competent and are legally okay for condoms and so on. They will get a little card that they can take to a distribution point to get free condoms. When they show the card, they will not receive a further educational session until after about 10 visits to a distribution point. They can go back to their youth worker or the school nurse, if they are running the scheme in school, or a different youth centre. It would be valuable for pharmacies to be part of this scheme as a distribution point. I am not suggesting that they have to run condom demonstrations telling young people how to use condoms, but if a young person is able to go in with their card, then they could receive a pack of condoms for free. That is particularly useful in places where youth services close down over school holidays. In the summer, for example, lots of rural youth services shut down. So, young people are unable to see their youth worker and access free condoms and other things. That would be really valuable for community sexual health service provision, particularly for vulnerable young people.

[129] **Mark Drakeford:** Thank you for that, because we had not covered that at all. It was helpful to add that. Jason, is there anything that we have not touched on that you think that we ought to have done?

[130] **Mr Harding:** Not really, but I have one suggestion for consideration, which is on the possible role that screening could provide in future when considering diabetes and other chronic conditions. The initiative that we delivered took five months and a lot of effort was put into it. We had a peak of activity for two weeks, but, for the 50 other weeks of the year, there is little opportunity for the NHS in Wales to be able to identify a person with a particular chronic condition who is undiagnosed and to get them into a treatment pathway to prevent complications and things becoming worse. It strikes me that putting a lot of effort into peaks of activity for public awareness is not a very good use of resource or of the information gained from the work conducted and to be able to deliver that continuously within pharmacy. So, to have an opportunity for some type of screening of chronic conditions continuously throughout the year, if that were possible, would be a more appropriate response to the nature of the situation that is currently seen in public health in Wales.

[131] For example, to focus your minds, we managed to identify 2 per cent of people undiagnosed with diabetes in Wales. When people are diagnosed with diabetes, 50 per cent have already had it for such a period of time that they are beginning to experience the complications of that condition. It is a similar position for other chronic conditions. Five per cent of people in Wales have diabetes, and they make up 15 to 20 per cent of in-patients in hospital beds. That is a direct result of people not managing the condition effectively and not being diagnosed early enough and therefore not managing the condition effectively. So, the cost-benefits of some good preventative screening work now would have a profound impact on overall NHS spend over the medium to long term.

[132] **Mark Drakeford:** Thank you for your evidence this morning. You will receive a transcript through the clerk to the committee, and if there are any factual or transcription inaccuracies, you will have a chance to draw our attention to those. In the meantime, I thank you both for your help this morning. Diolch yn fawr.

11.13 a.m.

**Papurau i'w Nodi
Papers to Note**

[133] **Mark Drakeford:** This paper had already been circulated before last week's meeting, but it is here more formally today. Mick raised a point last time about the precise figure that the department uses for constructing its idea of health inflation when dealing with budgets, which we are pursuing with the Minister for Health and Social Services. This is the last call for any other points that people feel need to be pursued separately with the Minister that are not covered in the letter. So, if anything occurs to anyone, I am sure that Llinos will take those points on board. We will write to the Minister formally on that basis.

11.14 a.m.

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

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

Mark Drakeford: I move that

[135] *y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog Rhif 17.42(vi).* *the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).*

[136] Gwelaf fod y pwyllgor yn gytûn.

I see that the committee is in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 11.14 a.m.
The public part of the meeting ended at 11.14 a.m.*