



Cynulliad Cenedlaethol Cymru The National Assembly for Wales

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

**Dydd Iau, 10 Tachwedd 2011
Thursday, 10 November 2011**

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

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

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

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

Eraill yn bresennol**Others in attendance**

Byron Grubb	Cadeirydd, Cyngor Iechyd Cymuned Aneurin Bevan Chair, Aneurin Bevan Community Health Council
Catherine O'Sullivan	Prif Swyddog, Cyngor Iechyd Cymuned Aneurin Bevan Chief Officer, Aneurin Bevan Community Health Council

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

Sarah Beasley	Clerc Clerk
Steve Boyce	Ymchwilydd Researcher
Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

*Dechreuodd y cyfarfod am 10.16 a.m.
The meeting began at 10.16 a.m.*

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

[1] **Mark Drakeford:** Bore da. **Mark Drakeford:** Good morning. I welcome Croesawaf aelodau'r pwyllgor i'r sesiwn y committee members to the session this bore yma. Fel y mae pawb yn gwybod, yr morning. As everyone knows, we operate ydym yn gweithredu'n gwbl ddwyieithog, totally bilingual, so you can listen to the felly gallwch wrando ar y cyfieithu ar y pryd simultaneous translation on channel 1 or

ar sianel 1 neu chwyddo'r sain ar sianel 0. amplify the sound on channel 0. Kirsty Bydd Kirsty Williams yn cyrraedd am 10.25 a.m. Fel yr ydym yn gwybod, ni all Darren Williams will be here at 10.25 a.m. As we know, Darren Millar cannot attend, and there is no substitution on his behalf. Millar fod yn bresennol, ac nid oes dirprwy ar ei ran.

10.17 a.m.

Y Dull o Ystyried Deddfwriaeth Approach to Legislation

[2] **Mark Drakeford:** We have before us a paper that has been drafted for us by the Legislation Office. I welcome Sarah Beasley and Joanest Jackson; most Members will know them. When we come to dealing with the legislative scrutiny that will fall to this committee, Sarah and Joanest will be our main guides through it all, and they are also responsible for the paper that you have seen. You will see that the paper rehearses a series of different ways in which we could go about involving ourselves in the organ donation White Paper, which was published by the Government earlier this week.

[3] Having had a chance to discuss it with others, my proposition is that we ought not to try to carry out our own parallel formal consultation exercise at this stage. The Government will conduct its own consultation. We do not want to put ourselves in the position of being a consultee to the Government's exercise; that is not a constitutionally proper relationship between a National Assembly committee and the Government.

[4] However, to ensure that we are properly prepared for the formal part in the process that we will have to play at Stage 1 of the Bill, we should have an early scrutiny session with senior officials who are responsible for the conduct of the Government's consultation exercise, to ensure that we know what the White Paper is intending to achieve, what they think the key issues are, how they intend to conduct their consultation and what arrangements they are putting in place to collect people's views and so on. Quite quickly after the consultation ends at the end of January, we should have a further session with them to hear what they think the consultation has taught them, what they think the main issues have been, how they intend to analyse and process the information they have collected and, particularly from our point of view, how they see that leading into a timetable for the production of the Bill, at which point we will have a formal part to play.

[5] However, I am completely open to any alternative views or variations that anyone may want to contribute.

[6] **Mick Antoniw:** I agree with that; that is our proper function at this stage. Bearing in mind the importance of this early legislation in the legislative process, we could at least have some briefing, whether that be from the officials or whomever, on the legislation that is referred to in other countries and so on, not for the purpose of examining what they have done, but because it would be interesting to see how they have done it. That would prepare the ground for when the draft Bill appears. One of the things that we will be looking at is how to make the legislation effective, rather than just its passage and all the supplementary things that probably need to go with this piece of legislation, which is a rather strange piece of legislation in some ways.

[7] **Mark Drakeford:** It will be useful for any committee member to notify the committee of any bits of information that they identify as being useful for us to have available to us to inform ourselves in advance of the job that we are going to do over the next couple of months. We can ask the clerks, Sarah and Joanest to start doing that work for us. The White

Paper period most usefully provides us with a chance to ensure that we are as well-informed and as best-prepared as we can be for the job that we are being asked to do.

[8] **Vaughan Gething:** I agree with that approach. I want us to be effective and, therefore, we need to ensure that we, as a committee, have the background knowledge and understanding of where the legislation is coming from. The previous Assembly undertook an inquiry into this area as well, so there are obvious things for us to consider as a committee. The path that you have set out regarding how we formally deal with the White Paper period, our input with officials about the purpose of the legislation, how the consultation is run and what happens afterwards is sensible.

[9] **Elin Jones:** I agree with everything that has been said. It is important that we, as a committee, do not mix up our role with the Government's role. More importantly, it is important that the general public do not mix them up and can make a clear distinction between the role of this committee and the role of the Government in promoting the legislation.

[10] **William Graham:** I endorse your proposal, Chair. Given that it will also be going to a legislation committee from this committee in time, it is important that we make that distinction. What you propose is very good.

[11] **Mark Drakeford:** Thank you. Another set of information that could usefully be put together for committee members, particularly people who were not present for the past four years, is the work that was produced during that period, partly by Government and partly by the committee. It would be useful for people to have a chance to digest all of that work.

[12] **Ms Jackson:** I was just going to offer to the committee that I put together a not overly complicated note on the current law, because it is quite technical. You will then be able to see where the White Paper is coming from. I promise that I will not make it overly technical, because it is currently a rather technical area of the law, but I have something that I could easily put together for you. I was going to suggest that the previous committee's reports would be a useful set of background papers.

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

[14] **Mick Antoniw:** What is the current state of the UK challenge as to whether we have the competence in this area? I thought that that challenge had gone away, but it appears that there are still issues that are arising or are being looked into with regard to the legislation, such as the human rights issues. It is important that we are at least aware of what is going on in the background.

[15] **Mark Drakeford:** Would you like to add that into your note, Joaneest, so that we are aware of what the issues are?

[16] **Ms Jackson:** Yes, of course.

[17] **Mick Antoniw:** It would also be useful to know what the possible impacts will be if this is taken further by Westminster.

[18] **Vaughan Gething:** If it is taken further, the difficulty is that it is one of those unknowns; we do not know what the Westminster Government is going to do in that sense. So, I think an understanding of the issue is where we should be, and then, if they want to challenge it, we will have to take a view, but, again, that is really an issue for the Government, in terms of the impact on Government legislation, to start with, and then the powers that we want to have. So, I would want clarity on the issue and not want to try to

presage anything else.

[19] **Mark Drakeford:** We might just want to be clear about the process. I think that I can just about remember that there is a six-week period after an Act is passed in which the attorney general can mount a challenge. I would be grateful just to be reminded of the specifics, so that at least we know what the landscape is. We cannot anticipate it, and we do not want to start worrying about what might happen, but at least if we know what the process would be, then we are informed.

[20] **Lindsay Whittle:** It is as well to be prepared for a challenge. I am sure that someone, somewhere in this building, is already onto that. We should meet that challenge head-on.

[21] **Mark Drakeford:** Yes, we should know.

[22] **Ms Jackson:** Bearing in mind the extent of any challenge, should it occur, it will be difficult to crystal ball-gaze, if you like, because we need to see the actual provisions of the Bill. At the moment, we do not know what the Bill is going to say. This was, from memory, raised in the last Assembly, when the proposed legislative competence Order was before the legislation committee, and if memory serves correctly, when the Minister was asked about the possibility of the human rights issue arising, the answer that always came was, 'It will depend on what is in the legislation'.

[23] **Mark Drakeford:** We will be able to ask some of these things this afternoon at the session with Daniel Greenberg. As we now know that we have a White Paper, he said that he would aim to focus at least part of what he would go through with us in terms of legislative scrutiny around that specific issue, knowing that that is what this committee will be taking on first. He said that he would be very open to anyone wanting to ask these sorts of questions. Finally, I remind anyone who is not able to be there, or who is having the session separately with another committee, that if they have a member of staff that they want to attend, either with them, or in their place, then that is an open invitation for this afternoon's event.

[24] That is very useful; thank you. We know what we want to do there.

Ymchwiliad i Gyfraniad Fferylliaeth Gymunedol i Wasanaethau Iechyd yng Nghymru—Tystiolaeth gan Gyngor Iechyd Cymuned Aneurin Bevan
Inquiry into the Contribution of Community Pharmacy to Health Services in Wales—Evidence from Aneurin Bevan Community Health Council

[25] **Mark Drakeford:** Bore da. Trown yn awr at y trydydd eitem ar ein hagenda. Y bore yma, byddwn yn clywed tystiolaeth gan Gyngor Iechyd Cymuned Aneurin Bevan. Croeso yn arbennig i Catherine O'Sullivan, prif swyddog y cyngor, a Byron Grubb, y cadeirydd. Yr ydym wedi cael cyfle i ystyried y papur y mae'r cyngor wedi ei ddarparu. Diolch am y papur hwnnw.

Mark Drakeford: Good morning. We now turn to the third item on our agenda. This morning, we will be hearing evidence from Aneurin Bevan Community Health Council. I welcome Catherine O'Sullivan, the chief officer of the council, and Byron Grubb, the chair. We have had an opportunity to consider the paper provided by the council. Thank you for that paper.

10.30 a.m.

[26] Before Members ask their questions, you have a couple of minutes to highlight the issues that were raised in the paper that you provided. We have three quarters of an hour to discuss the matter with you. Just before our time comes to an end, I aim to come back to you in case there are any points that have not arisen in the discussion that you are keen for us not

to miss.

[27] **Ms O'Sullivan:** To set the scene, community health councils have a statutory role to represent the interests of patients in the NHS. Part of that role is monitoring the services that are delivered, including by pharmacies. We undertake a specific role with pharmacies in monitoring their activities, premises, delivery and quality of services.

[28] **Mark Drakeford:** We are interested in discussing how the statutory duties that CHCs discharge feed into the views that patients might have about any extended role that community pharmacists might play in future.

[29] **Rebecca Evans:** To what extent is the community health council consulted on developments in community pharmacy? How does that consultation take place and how are you able to gather the views of the public to respond to it?

[30] **Ms O'Sullivan:** It is a slightly odd scenario, in that community pharmacy does not represent mainstream delivery of NHS services by a health board, an acute trust or even general practitioners' surgeries. We are consulted on any developments in relation to a new pharmacy or an application for a pharmacy to come to an area. We do not have much right, under the regulation, to object or agree; all that we can do is offer a view. It is a slightly convoluted and difficult way for us to operate. We always offer a view, but we do not hold out much hope that it will be taken on board.

[31] **Rebecca Evans:** What do you think is the level of knowledge and understanding by the general public of the services provided by community pharmacies?

[32] **Ms O'Sullivan:** I think that there is confusion. Based on the information that we receive, we see that the general public values pharmacies and that pharmacists are held in high esteem. However, so many pharmacists offer so many different levels of service. One will offer emergency contraception and a needle-exchange programme, while others will not. It is down to their personal choice as to which service they would like to offer in that locality. Some services are focused on local need, but it is down to the pharmacists as to what services they will offer. There is no consistency; there is a great variation between pharmacies.

[33] **William Graham:** Drawing from your evidence of patients' observations and complaints, how effective is community pharmacy in reaching groups that are difficult to reach? I ask you to include in your answer people who live in rural areas and those who have physical or learning difficulties.

[34] **Ms O'Sullivan:** We undertook a full service review of pharmacies in 2009, where we asked these specific questions about groups that are hard to reach and about providing services to those with learning difficulties or physical or mental health needs. The response in relation to disabilities was very positive. Pharmacists showed us the products that they use, such as magnifying sheets for people with sensory disabilities, loop systems and signage cards for people with severe learning difficulties. The level of service for that group of people is high. In relation to the homeless or other hard-to-reach groups, there was virtually no response on that. The response we got was either that it was not applicable to this area, or we do not get people coming into the pharmacy for things. That was an eye-opener for us. We subsequently prioritised going out this year to ask the homeless exactly how they access services, because we do not know. So, we need to find out.

[35] **William Graham:** What about the rural issue?

[36] **Ms O'Sullivan:** We have a mixture of dispensing GPs across rural areas. The rural area that I cover, namely Monmouthshire, has a little bit of a mixed bag, but most of the

populated areas have a pharmacy within the locality so, it is not so much of an issue.

[37] **Willam Graham:** In terms of those services which you described positively, are they consistent among all pharmacies in your area?

[38] **Ms O'Sullivan:** All the pharmacies that we visited, which was 28 per cent of the pharmacies across our patch, had positive outcomes on that aspect.

[39] **Mark Drakeford:** I am going to turn to Vaughan, Lindsay and Lynne for the next questions. First, may I ask a question on that specific, before we forget it? You mentioned in an earlier answer that one of the characteristics of pharmacies is that they vary a great deal. Do you detect at all whether that variation is more pronounced in rural areas than in urban areas, or is it just a matter of chance?

[40] **Ms O'Sullivan:** It is across the board really.

[41] **Vaughan Gething:** On the patient record issue, you talk in your evidence about the potential for pharmacists to have access to the records. Is it your view that pharmacists should be permitted to have access to the formal patient record?

[42] **Ms O'Sullivan:** Yes.

[43] **Vaughan Gething:** We heard in evidence from GPs' representatives that some patients may not expect their pharmacist to have access to the record and they would want additional consultations to take place before any steps were taken for that to happen. What is your view? Do you think that access to records is a good thing that should be allowed, and should there be additional consultation on what that would look like?

[44] **Ms O'Sullivan:** This is quite a difficult one as it relates to the professional perspective of what patients want and patients' perspective of what they want. The majority of patients that we would have contact with, and the public, always assume that all health professionals have access to every piece of information about them—information about every health issue that they may have. They expect the consultant in the hospital to know what the GP knows. They also expect the pharmacist to know it. They do not see the barriers that the professionals see. So, in the circumstances, it may be the GPs' view that the patients would not like it or would need intensive consultation, but it is an expectation of members of the public that communication is good across the NHS. They are shocked when they find out it is not.

[45] **Vaughan Gething:** That takes us to my final point, on barriers. We have heard a lot of evidence about barriers between different health professionals, and about the communication of expected outcomes from the local health board to people delivering primary healthcare. You have said that good communication between pharmacists and GPs is essential. Will you expand on the barriers that exist, and what is your view on the level of communication between GPs and pharmacists on shared patients?

[46] **Ms O'Sullivan:** I can probably answer some of that, but I would be offering an opinion rather than offering any evidence to back it up. Our council area was the pilot area for the individual health record scheme in Gwent. There was considerable resistance from GPs in the area for giving the out-of-hours service access to the patient health record. I am assuming that they will have the same view about pharmacists. That view was also expressed as regards sharing health records with emergency services in the acute sector. There is always concern about ownership of records and who should have access to them. However, that is a totally professional trait, and one that we have observed, rather than being one that I can state and guarantee.

[47] **Vaughan Gething:** That is interesting; thank you.

[48] **William Graham:** On this particular question, the previous health committee made a strong recommendation that the Ministry of Defence should share all its service personnel records with GPs. Do you have an opinion on that?

[49] **Ms O'Sullivan:** If you are going to offer continuity of care and support any clinician in establishing a history for a patient, that needs to happen. We do not want to see information getting into the wrong hands or going in the wrong direction, but surely clinicians who are delivering an NHS service should be trusted to maintain a patient's confidentiality. Anything that will support a patient to get the best treatment in the best way—

[50] **William Graham:** So, you would support that for pharmacists as well?

[51] **Ms O'Sullivan:** Yes.

[52] **Lindsay Whittle:** Good morning. I am concerned about patient confidentiality, because many people can attend a community pharmacy for treatment for a minor ailment, but one that may be embarrassing to them, and they may not want their friends, neighbours or even strangers hearing of it. We have heard evidence in this committee that not all pharmacies have a separate room where you can have a confidential consultation with a pharmacist, but that you simply have to ask over the counter. That is not acceptable, in my opinion. Did you receive any evidence to back that up?

[53] **Ms O'Sullivan:** When we undertook our review, we looked at some of the pharmacies that were offering medicine reviews and we demanded as a criterion, which is in the contract, for the delivery of that service that there had to be a separate consulting area and that patients were afforded that level of confidentiality. We have gone a little further and said that all pharmacies should have a separate area for discussion with patients about their drugs or their conditions. If you have a question, based on the drugs that you are taking, and you have to ask it in front of a store full of people, you will divulge information about yourself that you might not want to. So, the level of confidentiality within a store environment is not great and there should be a greater opportunity for private discussion in any pharmacy.

[54] **Lynne Neagle:** Good morning to you both. I wanted to ask about minor ailment services. We have heard evidence previously that Torfaen is one of the few areas where this service has taken off, but we have also heard that the health board is considering decommissioning it. What is your experience of those services locally? Have you had any feedback from users of those services as to how valuable they found them? I also wondered about the process. Does the health board, for example, have to consult with the community health council to get a view on how the service is working before it can consider withdrawing it?

[55] **Ms O'Sullivan:** It will have to consult us before it withdraws it, because it has been in situ for quite a long time. We were not consulted around the implementation of this scheme and would probably have had some views at that point had we been. It cannot take it away until it has come to the table to discuss it with us.

[56] We have had a mixed view from the public on this issue. Recently, we have heard quite worrying evidence of abuse or misuse of the system, where people will go into the pharmacy and say, 'I want two boxes of paracetamol, a box of Calpol and a head lice treatment, but under minor ailments', and the assistant behind the counter will say, 'Okay, just sign the form'. That was never the purpose of a minor ailment service. We are not saying for one moment that that is systemic across Torfaen pharmacies, but any misuse of that

service is an abuse, and it should not be allowed to happen. If someone wants some medication such as Calpol for a child, they also need a level of confidence that the child needs it; they want that discussion and debate, if they ask the questions. They should not be getting that from a shop assistant, as good as shop assistants can be; they need to speak to someone who can advise them appropriately. We have always had this concern in relation to free prescriptions, and we want to make medication readily available to patients. In the Gwent area, I believe, the Aneurin Bevan Local Health Board last year spent £6 million on prescriptions for over-the-counter drugs. That is a total shift away from what people were previously doing, and it is a real concern to us, because spending more money on products that we would normally go and purchase because we have a cough or a cold is suddenly becoming a burden on the NHS. We do not feel that that is the best way forward.

10.45 a.m.

[57] **Lynne Neagle:** To what extent do you think the minor ailments schemes are responsible for that?

[58] **Ms O'Sullivan:** Unfortunately, I cannot tell you. One of the issues that we have with these schemes is that they were set up without reasonable exit strategies or robust evaluation of how the service could have a positive impact on patients and on the NHS. There is no way to easily measure diverted consultations from a GP to a pharmacy, for example, because footfall to a pharmacy may be maintained and people may ask opportunistically, but they may still go to their GP. We have no way of measuring that. So, unless you can measure the value of the service and the positive impact that it has for patients, I would question whether you should jump in and deliver it until you have made a proper evaluation of it.

[59] **Mick Antoniw:** You make some interesting comments in your paper about training and expertise. Perhaps you could expand on them. Do you have any concerns about quality training and expertise across the board for pharmacists?

[60] **Ms O'Sullivan:** As a professional group, pharmacists are highly trained and highly qualified in their area of work. I do not know that they have any significant diagnostic training or whether their diagnostic skills are sufficiently honed to support a patient coming to them regularly where you might think that their symptoms perhaps need something else. It is horses for courses. GPs are excellent diagnosticians, and pharmacists have considerable knowledge about the interaction of drugs and how that can affect health, and they should be working together, not trying to do each other's jobs. That is just our opinion, though. If pharmacists are to go forward in this, they will need significant diagnostic training to support that level of minor ailment assessment.

[61] **Mick Antoniw:** In terms of any expansion or strategic development of the community pharmacy service, would that then be one of the prerequisites that you think would need serious consideration? Do you have any other areas of concern if there were to be an expansion? It seems to me that, to some extent, development has been a bit haphazard, and we are now getting to the stage where we are looking to formalise the structure. What are your main concerns about how that process might go forward?

[62] **Ms O'Sullivan:** I suppose that our main concern is that we need to make the messages on how to access healthcare simple. We do not want to see a lot of convoluted ways for people to get the same treatment. If people are worried, concerned or anxious, they go to a default position of phoning 999 or they go to an accident and emergency department. What we see is that almost 50 per cent of those attending an accident and emergency department do not need to be there. However, when people wait a week or two to see their GP, they become anxious or worried, and that takes over, so they go where they feel safe, where there are medics who will care for them—they go to accident and emergency departments. The concern

for us is not so much about the back-up of the clinical governance, which we would assume would be robust to enable any professional to take on these areas of work. It is about the messages that we offer to the public and how difficult we are making it. What is a minor ailment? What is a minor injury? Where do you go with a minor injury? Do you go to a GP, do you go to a minor injury unit or do you go to an accident and emergency department? If someone has a repeated cough and goes to different pharmacies that provide a minor ailment service but do not have access to the person's notes and therefore do not know that that cough has now persisted for nine months, are we missing the opportunity to fully assess that patient and provide them with the service?

[63] Rather than being concerned about the training angle, which we assume would be robust if the service was to be put in place, our concern would be the duplication of resource. Assuming that we are not going to be taking resources away from the GP to give to pharmacists to deliver, additional money will be required and people will still choose where they wish to go—whether to the GP or the pharmacist. If we are freeing up GP time to take on more complex cases and manage chronic conditions, it becomes an enhanced service from GPs and would incur additional costs. At what point do we tell people, 'This is the service; this is where you go for it; and this is how much we are going to pay for it'?

[64] **Mick Antoniwi:** So, it is the clarity of the pathway that is of concern. Thank you; you have answered my question clearly.

[65] **Elin Jones:** You have made some very interesting comments on minor ailments and enhanced services, but do you have any views on services that you believe could be appropriately delivered by community pharmacies that are not currently being delivered throughout Wales? We have had some discussions during previous evidence sessions in this committee about flu jabs and people's ability to receive these in a community pharmacy. We have heard different views on that from different directions. Do you have a view not just on flu jabs, but on any enhanced services that you consider would be an area of work that community pharmacies could look at?

[66] **Ms O'Sullivan:** We have not specifically gone out and asked patients for their views on this, but we do hold a view as a council. Unless pharmacists have access to patient records, the convoluted system of notifying the GP that someone has been vaccinated with a flu jab will create another stream of paperwork and there is the potential for errors. I am not sure whether that would be appropriate, but full communication would be necessary between those delivering primary care. I am not sure that we need another person offering the service that is offered through the GP practice. However that it is just the council's view.

[67] **Mark Drakeford:** I would like to ask you a question on that point, and a couple of other questions, and then we have a little bit of time if anyone would like to ask any follow-up questions. It was interesting to hear you refer earlier to the pilot scheme in Gwent regarding patient records. Do you think that the experience of that pilot scheme demonstrates that anxieties about information sharing are high in prospect but low in practice? Is it something that people worry about before they have done it, but once the system is up and running, many of those anxieties seem to evaporate?

[68] **Ms O'Sullivan:** During the three-year period, only two concerns were expressed by members of the public regarding sharing their health records with out-of-hours services, yet a number of concerns were raised by GPs in relation to their patients saying that they were very concerned and would not let it happen. We undertook a number of exit polls to find out patients' views rather than those of GPs and, during those exit polls, not one person identified a problem. That is when we really learned about the expectations of the patient. 'Doesn't it already happen?' was the most common response that we had from the public.

[69] **Mark Drakeford:** So, if there were to be enhanced information sharing between community pharmacies and GPs' central records, we might anticipate that some of the anxieties that people have in advance might not turn out to be real anxieties in practice.

[70] **Ms O'Sullivan:** There will always be someone who will be anxious, but I believe, from our experience, that it would be a minority of people rather than the majority. People are more concerned about someone knowing what is in their bank statements than they are about another health professional knowing what is best for them and how to treat them better or more appropriately.

[71] **Mick Antoniw:** You described my wife very well in your last point. [*Laughter.*] With regard to the future model for community pharmacies, up until now pharmacies have been developed almost on a shop model. However, we have seen the development of specific pharmacies in close proximity to GP surgeries and so on. Is there a particular model that you have in mind for what would be the ideal development of a community pharmacy? Should it, perhaps, even be part of a GP surgery, for example? Do you have any views as to what seems to work better or is more publicly acceptable and so on?

[72] **Ms O'Sullivan:** We are certainly seeing a range of new developments around health resource centres where there is co-location of many services. People like the idea of a one-stop shop, where they can see their doctor, get their prescription and access a pharmacist in the same facility so they can have their prescription dispensed. However, people choose many different avenues for prescriptions, depending on whether they are urgent prescriptions for antibiotics or are repeat prescriptions and so on. There is no one direction that we can pinpoint but, in fairness, we have not tried to look at how people use the service. We have only asked for their opinions on it.

[73] **Mick Antoniw:** Do you have any concerns or views on the development of the retail pharmacy? I am thinking of the Tesco or Asda-type pharmacy, which has a far higher commercial focus and orientation. One example that I have been given is that the reason why you always have to wait a while for your prescription in Tesco is because Tesco wants you to spend 20 minutes going round the shop before coming back to pick up your prescription. Do you see any potential adverse developments in retail pharmacy?

[74] **Ms O'Sullivan:** We have seen some difficulties over the years with pharmacies in supermarkets. One difficulty is delays in achieving a licence to dispense. The pharmacy will have been built, there will be someone there and over-the-counter medications available, and people will go there with prescriptions, but there will be no pharmacist to dispense them. Stores have put in mechanisms to transport scripts to another dispensing store and then bring them back later in the day but, obviously, that is not the most appropriate way for people to get their medications.

[75] We have also seen the larger stores bring in certain collection-and-delivery systems as a very commercial approach to encourage people to use that service rather than to go to their local pharmacy. That is not always maintained, which is a concern. It is not an NHS service; the collection-and-delivery service is very much a commercial enterprise. It is not something that patients can rely on, so when they come to rely on it and it is then removed, it is a significant concern.

[76] In the last three years, about 86 people have contacted us regarding community pharmacies, not with complaints, but with issues that they want to clarify. One point that has been raised, on a fairly regular basis, is the lack of continuity in chain pharmacies and those in retail stores. With a local independent pharmacist, there is generally the same pharmacist there every day, and there is a level of rapport with the community that the pharmacy serves. When there is a different pharmacist every day or every week, the rapport is lost. People feel

less comfortable with advice from someone who is unfamiliar.

[77] **Lynne Neagle:** When Community Pharmacy Wales came to give evidence to us, it told us that it felt that one of the big selling points was the accessibility of community pharmacies, with regard to their location and opening hours, and told us that it is a 24-hour-a-day, seven-day-a-week service, which raised a few eyebrows in the committee. What was your experience of the opening hours side of things in Gwent, and how much is that contributing to any plans to extend the role of community pharmacies?

11.00 a.m.

[78] **Ms O'Sullivan:** I have not known many pharmacies in Gwent to be open 24/7. That is quite an eye-opener for me. It is interesting, because we have had many issues over recent years when GPs stopped delivering surgeries on Saturday mornings. A whole range of pharmacies tried to withdraw, and did withdraw, Saturday morning openings. That caused quite a bit of concern, because people were then left from Friday afternoon right the way through until Monday morning, and if you go to an out-of-hours service, and you have a script rather than the drugs, where do you get that filled? There may be a pharmacy open on a rota for an hour on a Sunday, but that still means that you have to travel a considerable distance to access that pharmacy. If 24/7 delivery was guaranteed, then that would be really impressive. However, I doubt whether that could happen.

[79] One issue that has come across my desk over the past few years is unplanned closures, particularly of chain pharmacies, whereby people would drop off their prescription in the morning, go back in the afternoon and find that, for some unknown reason, the pharmacy was closed. We managed to change some of that, but it still happens. People require continuity of service if they are going to go to that service to get advice, medications dispensed or whatever it might be. There needs to be that continuity, otherwise people do what they always do, which is to go to the accident and emergency department.

[80] **Kirsty Williams:** Although it is not specifically the area that we are looking at, it is far too tempting not to let the opportunity pass to ask about the £6 million that you said has been spent on providing for free, through prescription, items that many people would have previously been required to purchase, or would have done so as a matter of course, over the counter from the pharmacy: ibuprofen, Calpol and all of those other usual items. Did you say that it was £6 million for your particular area?

[81] **Ms O'Sullivan:** Yes.

[82] **Kirsty Williams:** So, it would not be going too far to say that that is probably replicated in other areas. That is a significant amount of money, and we are scrabbling here trying to find ways of saving and re-prioritising money. Some of us would like to spend money on new cancer drugs, but we are told that there is not enough money to spend on those drugs. How could that problem be overcome, while also recognising that, for some families, the price of a bottle of Calpol is prohibitive? You would not want to harm those families, but, at the same time, £6 million spent in one local health board area alone on medicines that would previously have been bought over the counter is a lot of money. You would have to have a really good analysis of that to think that that was the optimum spend for the NHS. I would not mind spending £6 million on Calpol and ibuprofen if I knew that that was the best way of spending £6 million for the optimum health of people in Wales. However, I might have a different view if that £6 million could deliver better health outcomes, and it just meant that some people would have to pay for their Calpol.

[83] **Ms O'Sullivan:** That is a tricky one.

[84] **Kirsty Williams:** Is there a way around that?

[85] **Mr Grubb:** It is about educating the patient; there is no other way of doing it. Spending £6 million in Gwent alone for people to have aspirin on prescription is nonsense. It is absolute nonsense. General practitioners also offer different types of drugs, and may prescribe a much more expensive brand than is necessary. I do not know how to go about that issue.

[86] **Ms O'Sullivan:** There are a range of issues that impact on that £6 million expenditure. If there is a clinical need, then the GP must prescribe. However, a discussion should be had with the patient about the extent of their clinical need—whether it is a headache, a fever and so on. I really do not know the answer to that. What I do know is that we spend lots of money in lots of other ways in relation to prescribing, where it is really down to GP choice as to what drugs they prescribe. That is an area that may need to be addressed. In our review of pharmacy services, one issue that came out quite clearly was that, in one area of Gwent in particular, GPs were quite determined that they would still prescribe non-generic drugs and that they had the right to do so. However, the cost was quite significant. We made a recommendation to the health board at the time that surely there had to be some mechanism to bring GPs into line in what they prescribe. There are issues in there about GP dispensing as well, where the higher the cost of the drug, the higher the income. I am sorry, I am—

[87] **Mark Drakeford:** If we were to go into a wider discussion of prescribing policy we would end up with an awful lot of other issues on the table. It was worth airing that specific point, as you had raised it. I can see that a few others want to ask questions, but I want to bring us back, for a moment, to the more specific focus of our inquiry on community pharmacists, and I have a couple of questions for you on the patient's perspective. One of the big claims that those who advocate greater use of community pharmacy make is that, from the patient's perspective, it is easier and more convenient—you do not need an appointment and can just walk in off the street. From the community health council perspective, is that the way that patients see things? Do they share that view that convenience is one of the big pluses, compared to sitting in a GP surgery or waiting for an appointment?

[88] **Ms O'Sullivan:** It is a difficult question to answer, because there is no choice about the best pharmacist or GP. The choice has to be around access and convenience. People make a choice to go either to a pharmacy or to the GP, depending on their level of concern. Our position is, from what people have told us over the years, that anything that improves access to primary care has to be welcomed, but the cost, delivery and effectiveness of that service should be planned and evaluated against others before we step into this. There needs to be some evaluation of the one-stop walk-in centres that were developed in England. They seem to be hitting some difficulties, and an evaluation of those types of services could perhaps help to inform us as to whether this walk-in approach would improve—our fear is that we would be duplicating and creating confusion.

[89] **Mr Grubb:** A lot of people in the Valleys feel loyalty towards pharmacists; they become part of the community. I do not think that they would go into a 24/7 centre, if it ever came; they would rather keep their own, local pharmacy open. Just to go back to an earlier point, the more they can use pharmacies, the more it will free up GPs, and improve access to GPs, because we still have massive problems with GP access in Gwent, and the more pharmacists can do, then the more GPs can do on the more clinical side.

[90] **Mark Drakeford:** One technique that has been used by some pilot schemes in England, and is sometimes advocated by community pharmacists for overcoming some of these issues of quality and continuity and so on, is that patients register with a pharmacist. If a pharmacist was offering a minor ailments scheme, it would be the patient's choice entirely, but they could nominate the pharmacy as the place where they intend to access those services.

From a patient's perspective, do you think that there are pluses and minuses to that, and, if so, what would they be?

[91] **Ms O'Sullivan:** People use pharmacies in such different ways. Some will go to their local pharmacist regardless, and others will use whatever pharmacy they happen to pass. If we were to require registration, would that mean one registration, so that you could not register with another? Would it be the first step to booking an appointment with your pharmacist? There are lots of issues in there that could, further down the road, without appropriate planning, decrease access, so that would be a concern for us.

[92] **Mark Drakeford:** This is the last question from me, and then there are a couple of minutes for anything else. We heard from dispensing GPs that patients would be resistant to that service being diminished or to having a different sort of service. Is that the experience that patients report to you?

[93] **Ms O'Sullivan:** We have not come across any dispensing GPs that have had to stop dispensing in recent years. The experience that we have had in previous years has been that patients want what they have and what they have always had. There will be resistance to change. However, we also recognise the checks and balances of having a professional who is trained, qualified and an expert in dispensing working together with someone who is trained, qualified and an expert in diagnostics and how that can support patient safety. I would say that the majority of people who have a dispensing GP will fight to maintain that. Whether that is the right approach, I do not know. However, I do not think that you will see much change from the noes.

[94] **Elin Jones:** I am not sure, Chair, whether you will allow me to ask a question on the £6 million—

[95] **Mark Drakeford:** I will allow you, of course, this once. This is the last question, I think.

[96] **Elin Jones:** Just before everyone gets too excited as politicians and uses that figure in a particular way, I just want to understand it fully. Would that £6 million that you have identified be the money spent on those additional people who are now able to access free prescriptions, or would it include those who would have received free prescriptions under the ancient—sorry, previous—system? I was about to say 'ancien régime' or something, I think. *[Laughter.]* Sorry.

[97] **Ms O'Sullivan:** I have no way of answering that. I have no knowledge of that.

[98] **Mark Drakeford:** We know that 80 per cent of prescriptions were provided free of charge under the previous system. It is a good point.

[99] **Lynne Neagle:** It is an interesting point. You said that people were just going to the minor ailments service and saying 'I would like a, b, c, d and e' and, in some cases, were getting that. What are the mechanisms for monitoring the expenditure on that at health board level? Do you have any knowledge of that?

[100] **Ms O'Sullivan:** I know that any over-the-counter medications are claimed for by the pharmacist through the local health board. I am not sure that going into a pharmacy and saying, 'I want it on minor ailments' would be any different from going to a GP and saying, 'I want this on prescription'. I do not know that that would hike up the cost to any degree. However, I am concerned about patient safety. If over-the-counter medications can be offered without any real consultation with someone who is trained and qualified to provide you with reasonable advice, then I worry about patient safety. That is the aspect that would concern

me, because if they cannot get it at a pharmacy, they will go to the GP, so, I am not really sure that it is an added burden.

[101] **Mark Drakeford:** Thank you for the evidence, which I think has been really interesting and has helped us a lot with some issues that we have heard about from other people. You have given us some extra perspectives, which will be very helpful to us. If it is possible to have a copy of the review report that you mentioned, that would also be useful. I do not know whether the exit poll evidence that you referred to is in the public domain, but if you could let us see it, we would be grateful.

[102] **Ms O'Sullivan:** We can leave a range of evidence on patient surveys.

[103] **Mark Drakeford:** Excellent. Thank you very much. We have a minute or so remaining. If there are any points that have not come up in the questions that you think it important that we should not lose sight of, I would be glad if you could let us know about those, or for any final remarks.

[104] **Ms O'Sullivan:** I believe that it has been covered in discussion, but we feel that what is happening at the moment is making life very difficult for patients. We are making the messages too complicated. I do not know what a minor ailment is; I do not know what a minor injury is. Nobody does, until it is assessed properly. We are asking people to go from pillar to post and that is not going to help the NHS to modernise or encourage people to use services appropriately. Messages have to be clear, they have to be simple and services have to be accessed easily. That is the only thing that we can leave you with.

11.15 a.m.

[105] **Mr Grubb:** I think it is fair to say that this lack of communication about where to go is causing other problems, particularly in the Royal Gwent Hospital, where we had two horrendous days this year with 450 people coming in over a weekend, when 50 per cent of them did not even need to see a doctor at the accident and emergency department. They have come of their own accord. You cannot blame them. If you have a child who is ill and you cannot go to a doctor, you go to the nearest place. I feel sorry for people, but it is causing massive problems that there is no access to GPs, and/or pharmacists, where they are suitably qualified.

[106] **Ms O'Sullivan:** We blame patients for going to accident and emergency departments and using them inappropriately, but I think we should be more reflective. If we do not provide the right service at the right time in the right place people will go where they feel safe.

[107] **Mark Drakeford:** Thank you, that is a very useful point to end on, because it is right at the heart of what we are thinking about with regard to where services are best provided. *Diolch yn fawr iawn i chi*—thank you very much to you both.

11.16 a.m.

Papurau i'w Nodi Papers to Note

[108] **Mark Drakeford:** Trown yn glou at **Mark Drakeford:** We turn quickly to papers bapurau i'w nodi, am bum munud. to note, just for five minutes.

[109] You will see that we have not been receiving minutes of our meetings. We have been waiting daily to see when they will arrive. [*Laughter.*] I am keen that we do not get into a pattern of routinely rerunning the last meeting in looking at the minutes. Therefore, I propose

that minutes be distributed in advance with papers. Any Member who wants to raise anything in relation to the minutes is, of course, absolutely entitled to do so. However, if you are willing to let the clerk know that you want to do that, then, if no-one indicates that there is a point to raise, we will know that we can move past the minutes quickly. Is that too much to ask, or is that okay?

[110] **William Graham:** I am happy to notify the clerk. For 12 years, we have resisted 'matters arising'.

[111] **Mark Drakeford:** I am very keen to do the same. If anyone feels strongly that something has been reported inaccurately, they could raise it with the clerk. Unless there is anything really significant, the minutes will just be there for information. Excellent. Thank you very much.

[112] We have received a letter from the Petitions Committee referring a Tenovus petition on free sunscreen for children aged under 11 to us. It has also been referred to the Children and Young People Committee. My view is that the Children and Young People Committee has a remit to look at children's health and that, therefore, it is best placed to deal with that. I see that we agree.

[113] There is a letter from the Minister in response to our request for information about the Government's timetable for its review of adult mental health services. It helpfully sets out the track that the Government is on. Last time, I think that we felt we did not want to embark on a piece of work on mental health when we thought that the answer that we would get from the Government was, 'We're working on it at the moment'. However, this gives us a few pointers as to where we might want to do some work of our own.

[114] I need to put a couple of dates to you. We now have a date for the Scottish evidence that we are going to take on community pharmacy. We will do that on 24 November by video link. That is all agreed and in place. We have a date from the Minister to come to give evidence before Christmas on the community pharmacy inquiry, but we now also have a date from the Minister of 25 January to come for a more open cross-portfolio session at which we will be able to ask questions on anything that we choose to. That is in the diary and agreed.

[115] **Vaughan Gething:** The date the Minister is to come to us is 30 November. Do we have an alternative?

[116] **Mark Drakeford:** We are in discussions with the Minister's office about 30 November being a date that may not be available. Obviously, her office knows that, as we do, and it is looking to see what else it might be able to offer.

[117] Lastly—I almost forgot to mention this to you—as Chair of the committee, I had a meeting this week with someone who works with the retained fire service about the issue of co-responders and first responders. There are some issues in the service at the moment, but he also wanted to know whether the committee would be interested in undertaking a piece of work that looks at the contribution that first-responder and co-responder services might make in the future, particularly some rural aspects of it. During that meeting, Adrian Hughes—that is the person's name—said to us that Professor Siobhan McClelland had done the most recent and interesting work in this area. My suggestion, and we will send a note around about this, is that if perhaps one person from each of the political parties would want to come with me to a meeting with Professor McClelland to hear from her about the work that she has done, and to help us think about what the committee might do, we could come back to talk to everyone else about what we might usefully do in that area. If you are happy with that, we will fix a date and there will be an invitation.

[118] **William Graham:** Can we have something in writing also?

[119] **Mark Drakeford:** We could provide a note that lets people know what the concerns are and what the contribution might be in the future.

11.21 a.m.

**Cynnig Gweithdrefnol
Procedural Motion**

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

Mark Drakeford: I move that

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

17.42(vi).

[121] 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 11.22 a.m.

The public part of the meeting ended at 11.22 a.m.