Agenda – Public Accounts Committee

Meeting Venue:

Committee Room 4 – Tŷ Hywel

Meeting date: Monday, 17 July 2017

Meeting time: 13.30

For further information contact:

Fay Bowen

Committee Clerk

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Private

(The Committee agreed on 10 July 2017, a motion under Standing Order 17.42 to resolve to exclude the public from this meeting.)

1 Introductions, apologies, substitutions and declarations of interest

(13.30)

2 Paper(s) to note

(13.30 – 13.35) (Pages 1 – 3)

Hospital Catering and Patient Nutrition: Letter from the Welsh Government (6 July 2017)

(Pages 4 – 5)

Implementation of the Wales Act 2017: Letter from the Llywydd (11 July 2017)

(Pages 6 – 8)

3 Medicines Management: Reports from Stakeholder Event

(13.35 – 13.45) (Pages 9 – 20)

PAC(5)-21-17 Paper 1 – Report from visit to Glanrhyd Surgery, Ebbw Vale
PAC(5)-21-17 Paper 3 – Report from visit to Ty Elli Surgery, Llanelli
PAC(5)-21-17 Paper 3 – Report from visit to Stanwell Surgery, Penarth
PAC(5)-21-17 Paper 4 – Additional information from Abertawe Bro Morgannwg University Health Board (ABMUHB)

4 Auditor General for Wales Report(s): Update on forthcoming reports

(13.45 - 14.00)

5 Looked after Children: Stakeholder Event

(14.00 - 16.00) (Pages 21 - 59)

Research Briefing

Professor Donald Forrester - Director Cascade
Professor Sally Holland - Children's Commissioner for Wales
Professor Paul Rees - Swansea University
Sean O'Neill - Children in Wales

Concise Minutes – Public Accounts Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: Monday, 10 July 2017

Meeting time: 04.00 – 16.18

This meeting can be viewed on Senedd TV at:

http://senedd.tv/en/4115

Attendance

Category	Names
Assembly Members:	Nick Ramsay AM (Chair) Mohammad Asghar (Oscar) AM Neil Hamilton AM Vikki Howells AM Neil McEvoy AM Rhianon Passmore AM
Witnesses:	Dr Andrew Goodall, Welsh Government Alan Brace, Welsh Government
Wales Audit Office:	Huw Vaughan Thomas – Auditor General for Wales Matthew Mortlock Mike Usher
Committee Staff:	Fay Bowen (Clerk) Claire Griffiths (Deputy Clerk) Jonathan Baxter (Researcher) Katie Wyatt (Legal Adviser)

Transcript

View the meeting transcript (PDF 999KB) View as HTML (999KB)

1 Introductions, apologies, substitutions and declarations of interest

1.1 The Chair welcomed the Members to Committee.
1.2 Apologies were received from Lee Waters AM. There was no substitute.

2 Paper(s) to note

2.1 The papers were noted.
2.2 Governance Arrangements at Betsi Cadwaladr University Health Board (BCUHB): Auditor General for Wales' Report – An Overview of Governance Arrangements (29 June 2017). The Committee agreed to write to the Chair of the Health, Social Care and Sport Committee requesting that they scrutinise the Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health on this issue, during their regular ministerial scrutiny sessions.

2.1 Notification of Additional Accounting Officer at HMRC (13 June 2017)

2.2 Governance Arrangements at Betsi Cadwaladr University Health Board: Auditor General for Wales' Report – An Overview of Governance Arrangements (29 June 2017)

2.3 The Welsh Government's Funding of Kancoat Ltd: Letter from the First Minister (28 June 2017)

2.4 Natural Resources Wales: Response to the Committees' report

3 Implementation of the NHS Finance (Wales) Act 2014: Evidence session

3.1 The Committee took evidence from Dr Andrew Goodall, Director General/NHS Chief Executive and Alan Brace, Director of Finance, Welsh Government as part of their inquiry into the Implementation of the NHS Finance (Wales) Act 2014.

3.2 Dr Goodall agreed to send further details of the changes in performance indicators that have occurred in the Welsh Ambulance Service Trust.

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

4.1 The motion was agreed.

5 Implementation of the NHS Finance (Wales) Act 2014: Consideration of evidence received

5.1 Members considered the evidence received and agreed to publish a short report.

6 Forward Work Programme: Consideration of autumn 2017 work programme

6.1 Members discussed the forward work programme and noted its contents.
6.2 Members considered and subject to a couple of minor amendments, agreed the draft letter on the Circuit of Wales.

7 Inquiry into Regulatory oversight of Housing Associations: Consideration of the draft report

7.1 Members considered the draft report and suggested a number of amendments. The Clerks will circulate a revised version showing the changes, by email.

Agenda Item 2.1

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Department for Health and Social Services
Prif Swyddog Nyrsio - Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer - Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

Our ref: MA/VG/1623/17

Nick Ramsay, AM
Chair – Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

6 July 2017

Dear Mr Ramsay

LETTER RE: PUBLIC ACCOUNTS COMMITTEE REPORT RECOMMENDATIONS PUBLIC ACCOUNTS COMMITTEE HOSPITAL CATERING AND PATIENT NUTRITION REPORT
JUNE 2017

Thank you for your correspondence dated 8 June 2017.

With reference to your specific points:

Recommendation 1: It is not clear if the standing agenda item, for patient feedback on meals applies to the All-Wales Menu Framework Strategic Monitoring and Evaluation Group or to the annual joint meeting with the Nutrition and Catering Group.

Patient feedback on meals will be a standing item on the agenda at the joint meeting between the All-Wales Menu Framework Strategic Monitoring and Evaluation Group and the All-Wales Nutrition and Catering Group. This is to ensure cross reference between the work on menus and nutrition and catering.

Recommendation 4: Did the stakeholder event scheduled for 19 May 2017 take place and if so what was its purpose?

The stakeholder event took place on the 19 May with representatives from all health boards and NHS Trusts in Wales. The purpose was to share with attendees the work plan for the nurse e-documentation programme and to understand technical requirements of nursing documentation and information flow based on feedback received from a broad spectrum of nursing users.

Recommendation 5: We acknowledge the 'WIDI' initiative but are concerned that your response does not address the substantive point of our recommendation regarding reviewing workforce planning arrangements within NWIS.

While NWIS has not conducted a comprehensive review of its entire workforce planning arrangements it has put in place extended planning and recruitment timetables in order

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to fill technical posts. Competition for technical staff is high across sectors therefore NWIS works with NHS organisations to identify early the type of technical posts needed for the future. As a recent example NWIS has worked with health boards and NHS trusts to identify and recruit to a new technical architect role for the e-documentation programme with priority given to nurse documentation.

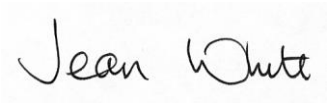
Recommendation 6: We welcome the intention to work with health boards to examine compulsory training for nutrition but wish to see a timescales for undertaking and concluding this work.

This work will be completed in the 2017/2018 year and therefore the deadline for the completion of the work is March 2018.

Recommendation 9: we are concerned that little or no progress has been made on this issue and request that the Welsh Government gives this issue utmost priority.

This issue is being given priority and a report on progress will be provided to the Public Accounts Committee by 30 September 2017.

Yours sincerely



Professor Jean White
Chief Nursing Officer
Nurse Director NHS Wales

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Public Accounts Committee

Medicine Management visit- 12 June 2017

Glanrhyd Surgery, Ebbw Vale

Glanrhyd Surgery and the pharmacist located in the adjacent pharmacy work closely together with patients regarding the management of their medicines. The surgery is located in a poor area of Wales and has high proportion of patients who have been diagnosed with Type II diabetes or are bordering on that condition due, in the main, to lifestyle choices. Patients with this condition receive a number of regular medicines, some of which are expensive, to assist in the management of the condition. The GP present in the meeting believes that an education/prevention programme/initiative together with patients changing their lifestyles could reduce the number of patients with this condition, improve lifestyles and save money as the number of prescriptions would be greatly reduced.

Lots of patient have drugs prescribed on a historic repeat prescription and don't realise that they can buy some of them, eg painkillers. There is a need for consistency amongst those prescribing, and at present the message is not really targeted properly. It was noted that alot of the surgery's patients are unable to afford to purchase these available medicines due to low incomes and reliance on benefits.

The surgery carries out regular (at least annual) medicine reviews to keep on top of the number of repeat prescriptions. This was complemented by the work of the pharmacists, who talk to patients about the items on their repeats and whether they are necessary. The pharmacist was very proactive in this area and would call patients with regular repeat prescriptions to discuss whether they actually required all the medicines that month. He also used this opportunity to discuss with patients compliance in their understanding of their prescribed medicines. There was support for better linking of IT systems and information, including access to the GP patient records, as there are a large number of interactions with patients. Often pharmacists would not know the background to prescriptions, which would help answer a number of queries. Conversely, pharmacists accessing the

patient record would be able to help GPs know how much of a prescription is dispensed.

De-prescribing is a challenge, it is a lot more difficult to stop something on a prescription than start it – it would be useful to have guidelines around how to have difficult conversations around stopping medication, and ensuring these are done in a respectful way. The patient representative stated older people worry about not getting medicines/having the repeat items stopped so have a tendency to order everything listed whether they require it or not.

There is often a lack of understanding with patients regarding what medicines do – which causes concern and worry. Lot of work done by pharmacists to explain what the drugs do, and why they are needed or not in the instance of repeat prescriptions.

The interface between primary and secondary care needs better management. The GP present felt that sometimes hospital consultants prescribe a cocktail of medicines to assist patients but perhaps do not look at the whole picture and cited the example of a 90 year old patient being prescribed a whole range of drugs for a heart condition and questioned whether this was good medicine management at the patients time of life.

The practice was very interested in the views of the patients who attended the meeting from a different practice. One pf the patients had chronic health problems and had to tale a cocktails of medicines daily which were dispensed in sealed bags for daily use to reduce the bulk of carrying multiple boxes and minimise management problems. However, some of the items, eg sterile water and syringes are dispensed in multiple packs so are not required monthly. The patients were very proactive in only ordered what was required each month and were very conscious about wastage. The patient explained that often at quarterly reviews, the consultant would alter the medications and wastage would occur on dispended medicines.

The patients also advise that their practice displays posters about their approach to not prescribing items which can be purchased easily over the counter. The GP present said she would discuss this approach worth her practice colleagues.

Medicine pack sizes were also discussed and it was felt that these should all be standardised, where possible, into 28 day packs which would correlate with repeat medicine prescriptions and help towards eliminating waste. Another possible initiative to help draw awareness to medicine coat would be to print the actual cost of each item on the prescription.

Public Accounts Committee

Inquiry into Medicines Management

Note from Visit to Ty Elli Surgery – Llanelli

1. The discussion began with reference to what action could be undertaken to reduce medicine wastage.

2. Patient representatives explained that in some instances the pack sizes medicines are provided in resulted in wastage particularly where disposable equipment used to administer the medication is provided. For example, syringes might be provided in packs of 60 and a patient may only use half but with the repeat prescription is provided with more which results in stockpiling.

3. A number of examples were provided of whereby upon review some patients were found to have had thousands of pounds worth of excess medication in their homes. The costs involved were described as 'staggering'.

4. Some patients feel reluctant to refuse excess medication for fear they might not be able to have it re-prescribed at a later date. This is particularly an issue in surgeries where there are difficulties accessing opportunities to undertake prescription reviews and patients may think it's simpler to keep medicines on their prescriptions.

5. Participants explained that constant review and updating of prescribing was required and also that there were three main difficulties that needed addressing. These included:

    - Patients ordering medicines they don't need
    - Prescriptions being complex and communication with the pharmacy breaking down at times
    - Hospital discharge notes not always reach the GP and mistakes can occur with prescriptions. Discharge sheets in many instances are still handwritten and cannot always be read by the GP and therefore it is not always clear whether medication has been stopped, increased or whether new medication has been prescribed.

6. Participants explored the idea of itemising the costs of each medicine listed on a prescription sheet as a means of raising awareness of the costs involved. One participant suggested that this 'would be a huge way forward'.

7. The discussion moved to a scheme currently being operated through pharmacies in Cardiff whereby pharmacies are receiving payment for identifying unwanted prescribed items. This is achieved through the pharmacists asking patients questions about the items on their prescription and whether all of the items are required. Feedback on the scheme has been positive.

8. Participants focused on the importance of pharmacists being able to 'engage face to face' with patients to improve the efficiency of medicines management. However, it was noted that while pharmacists have a key role they face some push back from patients who ask why the pharmacist is questioning them as they are not GPs. Participants also identified a reluctance by patients to talk to pharmacists in detail and don't like going into consultancy rooms where matters can be discussed in private and in more detail.

9. Constraints on pharmacists time was also flagged up as a barrier to increased interaction with patients. Pharmacists are so busy dispensing they do not have time to talk to patients and review their prescriptions with them. Reference was made to good practice in Norway where pharmacists will always receive the prescription and always dispense it to the patient so a conversations can take place.

10. The issue of the prescribing of antibiotics was raised and participants explained that regular meetings were held with Health Boards to discuss the prescribing of antibiotics and undertake bench marking exercises. It was explained that Llanelli was one of the worst performing areas with the Hywel Dda Health Board in terms of the levels of antibiotics prescribed although it was noted that this was a reflection of the depravation and demographics within the area rather than any other factor.

11. A key issue regarding the prescribing of antibiotics is that of patient expectation and a marked increase in patients demanding antibiotics and getting upset when they are refused. There has been a marked increase in patients challenging the advice of the GP.

12. Improved synchronisation of prescribing was identified as another effective means of managing medicines wastage. It was explained that in instances whereby patients have to order some medicines every 28 days and others every 26 days. In such case multiple prescriptions are issues which increased the scope for duplication and mistakes.

13. Participants referred to the increase in prescriptions for medication to treat low levels of depression and that such an increase usage cannot continue. It was suggested that most patients requesting medication to treat depression were unhappy for other reasons and not diagnosed with clinical depression. The discussion focussed on the move towards 'social prescribing' as means of addressing this issue with GPs encouraging patients to participate in social activities. A scheme was being used in Llanelli whereby patients are provided with opportunities to undertake volunteering work in exchange for credits that can be spent on various social activities such as visits to theme parks or the theatre. The purpose is to assist individuals to interact and have social occasions to look forward to.

14. Social prescribing was seen as being vitally important with a view that it wasn't possible to separate medicinal and social needs. It was suggested that if social needs could be better met this would reduce the need for medication.

15. There were some discussions around approaches taken in England whereby the prescribing of products that can be purchased, such as calpol, paracetamol and gluten free products, have been stopped. However, participants raised concerns that in poorer areas such an approach would mean that some people would be unable to afford these products and be forced to go without.

16. This prompted a discussion on prescription charges upon which there were mixed views both for and against.

Public Accounts Committee

Medicine Management visit- 12 June 2017

Stanwell Surgery, Penarth

Stanwell Surgery have taken a proactive approach to not prescribing items which can be purchased easily over the counter. This initiative has come from a Health Board direction, but has not been taken up by all the surgeries. To help with the implementation of this policy, the surgery has produced a letter to give to patients, there is also a letter from the Health Board – which can provide some additional cover to the potential questions about why items are not prescribed. This was broadly welcomed with patient representatives expressing concerns about being prescribed things which could be easily brought. (Note of caution – items are not just prescribed to save patient money, in some instances these seemingly easily purchased drugs are included to ensure that patients are aware they need them, and that they are being taken)

Lots of patients have drugs prescribed on historic prescriptions and don't realise that they can buy them. There is a need for consistency across Health Boards amongst those prescribing, and at present the message is not really targeted properly.

The surgery carries out regular (at least annual) medicine reviews to keep on top of the number of repeat prescriptions. This was complemented by the work of the pharmacists, who talk to patients about the items on their repeats and whether they are necessary.

De-prescribing is a challenge, it is a lot more difficult to stop something on a prescription than start it – it would be useful to have guidelines around how to have difficult conversations around stopping medication, and ensuring these are done in a respectful way.

Electronic prescribing within a primary care setting is necessary. Currently all scripts are signed by hand, which takes up a significant amount of time. There is little safeguard in continuing with hand signing (often an argument used for not introducing electronic prescriping), as the checks and balances are in place with pharmacists.

There is often a lack of understanding with patients regarding what medicines do – which causes concern and worry. Lot of work done by pharmacists to explain what the drugs do, and why they are needed or not in the instance of repeat prescriptions. Patients need help taking medicine, often embarrassed by things like needing to use a dosset box. In some instances district nurses are being utilised to help patients take medication which is not a very efficient use of resources – although they are then able to check on any potential stockpiles, which is useful as accessing patients homes to check the quantity of medicines can be difficult.

The question should be posed of why the NHS contract for certain drugs is so much more expensive than the supermarkets. The differentiation between the tariff price and the concession price can be quite substantial and subject to significant fluctuations.

The restriction of medicines to one type can be problematic for the patient as once size does not fit all e.g. needles for diabetics, there needs to be a balance and some choice. Medicines are not effectively managed without spending some time and resource to identify ways to save resources.

The interface between primary and secondary care needs better management. Often patients are prescribed the '*new and more expensive'* drugs in hospital – as there are not the same incentives to consider the cost of medication in hospitals, and it is difficult to take someone off a certain medication as patients think '…but my consultant prescribed that'.

It can be frustrating that people are sent in with medication lists and then on discharge there often appears to be no reconciliation with the original list. Furthermore, if drugs have been omitted, the reason for the omission is not always clear and whether it is intentional. Although MTED does provide some information, there was a reluctance to put too much faith into it as often in the more complicated cases GPs will want to meet and discuss the medication with patients. There appears to be a lack of understanding about the costs of certain prescriptions from hospitals – they can end up costing GPs £1000's.

There was support for better linking of IT systems and information, including access to the GP patient records, as there are a large number of interactions

with patients. Often pharmacists would not know the background to prescriptions, which would help answer a number of queries. Conversely, pharmacists accessing the patient record would be able to help GPs know how much of a prescription is dispensed.

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Agenda Item 5

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