

# Medicines Management

March 2018



The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales, agrees Welsh taxes and holds the Welsh Government to account.

An electronic copy of this document can be found on the National Assembly website: [www.assembly.wales/SeneddPAC](http://www.assembly.wales/SeneddPAC)

Copies of this document can also be obtained in accessible formats including Braille, large print, audio or hard copy from:

**Public Accounts Committee  
National Assembly for Wales  
Cardiff Bay  
CF99 1NA**

Tel: **0300 200 6565**

Email: **[SeneddPAC@assembly.wales](mailto:SeneddPAC@assembly.wales)**

© **National Assembly for Wales Commission Copyright 2018**

The text of this document may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading or derogatory context. The material must be acknowledged as copyright of the National Assembly for Wales Commission and the title of the document specified.

# Medicines Management

March 2018



## About the Committee

The Committee was established on 22 June 2016 to carry out the functions set out in Standing Orders 18.2 and 18.3 and consider any other matter that relates to the economy, efficiency and effectiveness with which resources are employed in the discharge of public functions in Wales.

---

### Committee Chair:



**Nick Ramsay AM**  
Welsh Conservative  
Monmouth

### Current Committee membership:



**Mohammad Asghar AM**  
Welsh Conservative  
South Wales East



**Neil Hamilton AM**  
UKIP Wales  
Mid and West Wales



**Vikki Howells AM**  
Welsh Labour  
Cynon Valley



**Rhianon Passmore AM**  
Welsh Labour  
Islwyn



**Adam Price AM**  
Plaid Cymru  
Carmarthen East and Dinefwr



**Lee Waters AM**  
Welsh Labour  
Llanelli

---

The following Members were also Members of the Committee during this inquiry:



**Mike Hedges AM**  
Welsh Labour  
Swansea East



**Neil McEvoy AM**  
Plaid Cymru  
South Wales Central

# Contents

<b>Chair’s foreword .....</b>	<b>5</b>
<b>Recommendations .....</b>	<b>7</b>
<b>1. Introduction.....</b>	<b>10</b>
Background to the Auditor General’s report.....	10
Why this is important.....	11
<b>2. The profile of Medicines Management within the NHS Wales.....</b>	<b>12</b>
Public Information Campaigns.....	14
<b>3. Pharmacists’ contribution to effective medicines management</b>	<b>15</b>
Choose Pharmacy and Independent Prescribing.....	17
Making best use of pharmacists in clusters: extended roles and preventing demand in GP surgeries .....	22
The Pharmacy model.....	26
<b>4. Prudent prescribing.....</b>	<b>31</b>
Medication and Prescribing Errors .....	33
Automated Ward Vending .....	35
Prescribing medicines that can be bought over the counter.....	37
Repeat Prescriptions .....	40
<b>5. Interface between primary and secondary care .....</b>	<b>44</b>
Discharge information from secondary to primary care .....	44
Out-Patient dispensing in the community.....	46
The GP record.....	47
<b>6. Electronic Prescribing .....</b>	<b>50</b>
Electronic prescribing in secondary care.....	50
Electronic prescribing in primary care.....	53
<b>Annex A – Witnesses .....</b>	<b>55</b>
<b>Annex B – Record of outreach visits.....</b>	<b>56</b>



## Chair's foreword

The issue of medicines management is one which is relevant to everybody, from GPs, medical staff in hospitals, pharmacists, and patients. We all have a responsibility to ensure that medicines are not wasted or dispensed unnecessarily. Everyone on the Committee has had experiences of relatives or friends or constituents ending up with medicine cabinets full of medicines and the difficulties of getting items taken off repeat prescriptions.

Medicines are naturally a substantial element in the health budget, with £800 million spent and over 79.5 million medicines dispensed each year, in the primary care setting alone. It is crucial therefore that we have ongoing conversations about how this can be more effectively managed and what we can do to improve the issues of medicines management.

What we found during this inquiry was a system needing to change and a system not able to maximise its potential. Despite the Welsh Government support for greater use of pharmacists in primary care, this is not being realised – the Chief Pharmaceutical Officer told us over a 1,000 consultations a month are taking place with pharmacists – but this equates to approximately only 250 a week and these levels are nowhere near enough to achieve real system change.

We heard how cluster pharmacists are unable to plan strategically as the funding is not on a long term footing, and how there appeared to be professional tensions between GPs and Pharmacists about the level of the value that can be added by independent pharmacists. The Royal Pharmaceutical Society called for a better utilisation of the pharmacy resource within NHS Wales to release capacity and focus resources in the most appropriate way and the use of medicines to be optimised for effective and safe healthcare. We want to know how the Welsh Government intends to deliver this with the ambition and pace needed.

Alongside this, we found an IT project, for the delivery of Electronic prescribing and medicines administration, has been dogged by delays and a lack of progress, and the Medicine Transcribing and e-discharge system, which has been rolled out in some health boards, having had a mixed reception. These issues are seemingly symptomatic of wider issues within the NHS around delivery of major IT projects, which the Committee will explore further in our work on the NHS Wales Information Systems.

The Committee would like to thank everybody who gave evidence to this inquiry, and those who participated in the outreach visits, particularly the GP surgeries that hosted us.

Nick Ramsay AM  
Chair, Public Accounts Committee



## Recommendations

**Recommendation 1.** The Committee recommends that the Welsh Government produce an annual report detailing information of improvements in medicines management across all the Health Boards, to increase accountability and ensure that the profile of medicines management remains high on the agenda of Health Boards..... Page 13

**Recommendation 2.** The Committee recommends that the Welsh Government issue a national directive that all Health Boards need to develop campaigns to raise the profile of medicines management. These campaigns should be based on examples of best practice from the existing campaigns which have been built up from a local level..... Page 14

**Recommendation 3.** The Committee recommends that the Welsh Government sets out a plan to maximise the use of pharmacy resource, including developing the modules for delivery in choose pharmacy and enabling independent pharmacists. This plan should build on the recommendations in the Royal Pharmaceutical Society report..... Page 22

**Recommendation 4.** The Committee recommends that the Welsh Government develops a data management system to track the number of pharmacists working in Wales and the roles being undertaken. This can also be utilised to plan training needs and requirements. Consideration should also be given to extending this to include information on wider pharmacy staff such as technicians who also have evolving roles which may impact on the training needs of the sector ..... Page 22

**Recommendation 5.** The Committee recommends that the Welsh Government undertake an evaluation of cluster pharmacists, which evaluates the funding model and recruitment model for pharmacists within the cluster model. .... Page 26

**Recommendation 6.** The Committee recommends that the Welsh Government amends the Community pharmacy contract to achieve the necessary changes to release the full potential of the pharmacy sector and realise the aim of moving from a quantity to a quality based set of arrangements, and implementation timescales. .... Page 30

**Recommendation 7.** The Committee recommends that the Welsh Government plans for the emerging technologies in prescription packages facilitating the use of unopened medication when it does not compromise patient safety including the necessary legislative changes that may be needed, to ensure maximum advantages for any savings can be achieved..... Page 33

**Recommendation 8.** The Committee recommends that the Welsh Government investigates ways of harnessing the academic expertise in Wales to understand the scale of Medicine Related Admissions and how to reduce them..... Page 35

**Recommendation 9.** The Committee recommends that the Welsh Government provide an update on the automated vending evaluation work which was due to have been completed by June 2017..... Page 37

**Recommendation 10.** The Committee recommends that the Welsh Government co-ordinates a piece of work to share best practice from Health Boards relating to automated vending to help inform future decisions on medicine storage approaches. .... Page 37

**Recommendation 11.** The Committee recommends that the Welsh Government identifies whether any lessons could be learnt from NHS England relating to guidance on items which should not be usually be prescribed and the potential savings this approach may deliver. .... Page 40

**Recommendation 12.** The Committee recommends that the Welsh Government produces a report on best practice on repeat prescription ordering by cluster groups within the care home settings to help inform policies and actions on repeat prescriptions. .... Page 43

**Recommendation 13.** The Committee recommends that the Welsh Government provides an update on the work of the prudent prescribing group in relation to its work on the various models for repeat prescribing systems in September 2018 to allow the Committee to monitor progress on this..... Page 43

**Recommendation 14.** The Committee recommends that the Welsh Government evaluates the roll out of Medicines Transcribing and e-Discharge system to consider the progress and the benefits of this approach. .... Page 46

**Recommendation 15.** The Committee recommends that the Welsh Government provide an update on the progress against the Auditor General’s recommendation on the GP record and the other outstanding recommendations in the Auditor General’s report..... Page 48

**Recommendation 16.** The Committee recommends that as part of the Welsh Government’s commissioning and roll out of an new e-prescribing system, it develops a supporting plan of action to help achieve the cultural shift that needs to accompany the introduction of a new system. .... Page 52

**Recommendation 17.** The Committee recommends that the Welsh Government shares its action plan and key milestones for the Electronic Prescribing and Medicines Administration (EPMA) system with the Committee. .... Page 53

## 1. Introduction

1. The Auditor General for Wales (the Auditor General) published his report on **Managing Medicines in primary and secondary care** in December 2016.<sup>1</sup> The report concluded that:

- While there are many good aspects of medicines management, and health bodies are collaborating well to improve services, it needs a higher profile within health bodies.
- NHS Wales is taking positive steps to improve primary prescribing, but there is further scope to improve quality and cost.
- In hospitals, pharmacy services are rated highly by NHS staff but there are problems with medicine storage, gaps in information about medicines, and the delay in implementing a national electronic prescribing system is frustrating efforts to improve safety and efficiency.

2. The Public Accounts Committee considered the report alongside the Welsh Government response<sup>2</sup> at its meeting on 30 January 2017, and agreed to undertake an inquiry into the management of medicines within the primary and secondary care setting. In addition to holding formal evidence sessions (Annex A), the Committee undertook a number of public engagement visits. The record of these visits are included at Annex B.

3. Lee Waters declared an interest at the start of this inquiry as his wife works for Cwm Taf University Health Board.

### Background to the Auditor General's report

4. The report set out four key underpinning conclusions:

- **Corporate arrangements:** Health bodies are collaborating well but there is scope to raise the profile of medicine management issues, improve local planning and strengthen scrutiny of performance.
- **Primary care:** NHS Wales is taking positive steps to improve medicines management in primary care although there is scope to make prescribing safer and more cost effective.

---

<sup>1</sup> Auditor General for Wales Report – **Managing medicines in primary and secondary care**, December 2016

<sup>2</sup> Written evidence, **PAC(5)-04-17 Paper 9**, 30 January 2017

- **Interface between primary and secondary care:** There are medicines-related safety risks and inefficiencies when people move in and out of hospital.
- **Acute hospitals:** Pharmacy services are rated highly by medical and nursing staff but there are problems with medicines storage, gaps in medicines information and frustration at delays in implementing electronic prescribing.

**5.** The Auditor General’s report contained 10 recommendations, 9 of which were fully accepted by the Welsh Government in their response to the report Recommendation 3a was partially accepted:

**6.** Recommendation 3a: Health bodies should ensure their Chief Pharmacist is, or reports directly to, an Executive Director.

### Why this is important

**7.** With over £800 million spent on medicines and over 79.5 million medicines dispensed within communities in Wales per year, NHS Wales use medicines on a substantial scale. In the last 10 years there has been a 46 per cent increase in the number of items dispensed within communities, and in the face of this growing demand, the Welsh Government is urging prudent prescribing, to optimise people’s medicines so that patients receive the best possible outcomes and the NHS gets value for money from medicines.

**8.** We believe that there are number of areas, where medicines management could be improved to enhance efficiency and value for money in the NHS. This was a view which was echoed by those working within the NHS, and, for example, Dr Carwyn Jones from Furnace House Surgery, Carmarthen, told the Committee that:

“... I’m glad that the committee are looking at this because, speaking as a GP of 30-odd years, it’s an area where there is considerable room for improvement.”<sup>3</sup>

---

<sup>3</sup> National Assembly for Wales, Record of Proceedings (RoP), 16 October 2017, Paragraph 15

## 2. The profile of Medicines Management within the NHS Wales.

**9.** The Auditor General found that:

“...all health bodies have medicines management groups but the names, memberships, remits and reporting lines vary across Wales. A general issue across Wales is that these groups tend to be driven primarily by pharmacists, with more limited involvement from doctors and nurses.”<sup>4</sup>

**10.** The Committee questioned witnesses on whether medicines management should have a higher profile within NHS bodies. Dr Andrew Goodall, Director General/NHS Chief Executive argued that:

“...it does have a high profile. In my experience, it always has done over the years, and I think it has to have a high profile for reasons of safety, quality and finance. It would be true to say that the ‘Trusted to Care’ review and its focus around, for example, medication storage, has made sure that, from a professional perspective, we really do need to understand the safety and control issues around all of that. I think in the financial environment that public services are working in, actually, it’s really important to make sure it’s very high profile in terms of recognising the level of spend that we have in Wales.”<sup>5</sup>

**11.** Carol Shillabeer, Chief Executive, Powys Teaching Health Board (PTHB), told the Committee that in Powys

“... the profile, I think, if we look back a couple of years ago, was probably not as high profile, but certainly with the work of the last year to 18 months and now with a medical director in place, I can confirm that that receives one of the highest profiles across the health board.”<sup>6</sup>

**12.** The Committee noted that the Welsh Government response set out that the Welsh Government’s Efficiency, Healthcare Value and Improvement Group will be taking forward an all-Wales approach to cost and quality improvement in

---

<sup>4</sup> Auditor General for Wales Report, Managing medicines in primary and secondary care, December 2016, Paragraph 1.10

<sup>5</sup> RoP, 6 March 2017, Paragraph 113

<sup>6</sup> RoP, 19 June 2017, Paragraph 329

medicines management in 2017-18. That approach will be based around six specific areas: driving efficiency; reducing medicines related harm; improving patient experience and outcomes; workforce modernisation; building capacity through collaborative working; and improving access to information.

**13.** The Committee questioned the Welsh Government about how these plans are being taken forward. Alan Brace, Director of Finance, explained that there is a joint board between the Welsh Government and the NHS, which considers technical efficiencies (getting more out of the current investment) and allocated value (using resources to get the best outcome for people based on identified needs). He told the Committee that a framework had been developed by the NHS which has been populated with:

“... what the opportunities are for improvement, so that, I guess, gives us a bit of information about the benchmark opportunities for us to do better. They’ve all shared their current plans, and populated that, so we can see the variation across Wales.”<sup>7</sup>

**14.** Judith Vincent, Clinical Director for Pharmacy and Medicines Management, Abertawe Bro Morgannwg University Health Board (ABMUHB), explained how this work was being carried out at a strategic level, outlining that the Chief Pharmacists have produced a paper setting out prescribing areas where they would not recommend. This paper contained five target areas in primary care and five target areas in secondary care.<sup>8</sup>

**15.** The Committee welcomes the Welsh Government’s undertaking to utilise the Efficiency, Healthcare Value and Improvement Group to deliver an all-Wales approach to medicines management, but we are unclear how the Welsh Government intends to hold NHS bodies to account for delivery of plans to improve medicines management. Given the importance of this area, we believe that this needs to have a significantly higher profile, and want to see clear evidence of improvements

**Recommendation 1.** The Committee recommends that the Welsh Government produce an annual report detailing information of improvements in medicines management across all the Health Boards, to increase accountability and ensure that the profile of medicines management remains high on the agenda of Health Boards.

---

<sup>7</sup> RoP, 6 March 2017, Paragraph 163

<sup>8</sup> RoP, 19 June 2017, Paragraph 350

## Public Information Campaigns

**16.** Some health boards have produced public information campaigns to raise the profile of medicines management, for example “Your Medicines, Your Health” in Cwm Taf University Health Board (CTUHB) and “Only Order What you Need” in ABMUHB. The Committee questioned the health boards on the public information campaigns to raise the profile of medicines management and whether there was a need for separate, distinct campaigns, or if it would be better to have a coherent, all-Wales approach. There was a general consensus that there may be a benefit from a national branding and approach, although Allison Williams, Chief Executive, Cwm Taf University Health Board explained that:

“...because of the granularity in the way that some of these campaigns have been developed with local people in Cwm Taf, with the schools, and with children, we’ve been trying to look at how we infiltrate and get the message into the community and taken the view that, by growing the campaign from within the community, we’re probably going to get greater granularity. In all honesty, there’s probably room for both.”<sup>9</sup>

**17.** The Committee believes that everybody including medical staff, pharmacists and the public have some responsibility for medicines management. The role and responsibilities of the public in medicines management needs to be clear and widely understood. We believe there would be some benefit in there being a national directive to ensure campaigns are developed, and enable consistency in getting clear and concise messages across health bodies. However, these campaigns need to be owned by all those involved, so must be developed at a local level.

**Recommendation 2.** The Committee recommends that the Welsh Government issue a national directive that all Health Boards need to develop campaigns to raise the profile of medicines management. These campaigns should be based on examples of best practice from the existing campaigns which have been built up from a local level.

---

<sup>9</sup> RoP, 19 June 2017, Paragraph 365



### 3. Pharmacists' contribution to effective medicines management

**18.** In its report *Your Care, Your Medicine: Pharmacy at the Heart of Patient Care*,<sup>10</sup> The Royal Pharmaceutical Society in Wales calls for better utilisation of the pharmacy resource within NHS Wales and for pharmacists to be more fully integrated into clinical teams. The report highlights how pharmacist input can support patients in the effective management of their medicines. It also identifies a number of actions that need to be taken in order to achieve more patient-centred pharmaceutical care. These actions include having a sustainable funding model for pharmacy services in Wales, investment in new technology, workforce planning, pharmacy skill mix reviews, and alignment of contractual arrangements between pharmacists and other primary care contractors. The Committee supports this ambitious call to maximise the resources available and would welcome clarification from the Welsh Government on how this will be delivered.

**19.** The Auditor General's report highlighted the beneficial development of cluster pharmacist roles, as part of primary care clusters and the positive relationship between pharmacists, doctors and nurses within the secondary care sector. However, the Auditor General's report also identified scope for more consistent clinical pharmacy input into ward-level work and contact with patients and highlighted problems with the availability of hospital pharmacists outside of normal working hours.

**20.** The Auditor General's report also sets out the main issues facing the pharmacy workforce and resources. It indicates that often pharmacy resources are not fully considered when new services are being designed, and that a national service specification could help health bodies plan the pharmacy services they need to meet demand.

**21.** During the outreach visits undertaken by the Committee, participants told us about the important relationship between pharmacists and GPs, the challenges they face and the improvements that were needed. For example, at the Stanwell Road Surgery in Penarth, Members heard support for better linking of IT systems and information for GPs and pharmacists, including access to the GP patient records (these issues are explored further in later chapters). As there are a large number of interactions with patients in pharmacies, it was suggested it would be

---

<sup>10</sup> The Royal Pharmaceutical Society in Wales Report, ***Your Care, Your Medicine: Pharmacy at the Heart of Patient Care, October 2016***

---

useful for pharmacists to know the background to prescriptions, which could help answer a number of queries, as to what something had been prescribed for and why the medicine(s) were necessary. Conversely, pharmacists accessing the patient record would be able to help GPs know how much of a prescription is dispensed.

**22.** Similarly, participants at the Llanelli visit focused on the importance of pharmacists being able to “engage face to face” with patients to improve the efficiency of medicines management, being able to ask patients about their medicinal needs and identify any inefficiencies. However, it was noted that while pharmacists have a key role in achieving this they face some push back from patients who ask why the pharmacist is questioning them as they are not GPs. Given work has been undertaken by NHS Wales to promote the role of the pharmacist and ensure that patients are aware that pharmacists have skills and knowledge around prescribing, perhaps more could be done to raise their profile as being able to assist with prescription advice.

**23.** Elen Jones from the Royal Pharmaceutical Society Wales, explained that pharmacists have an important role to play as they have an expertise in medicines and:

“...with the ever-increasing complexity of medicines themselves and also the increasing complexities of patients with more and more long-term conditions, it is vital that pharmacists are a real component part of that multidisciplinary team. We are seeing pharmacists being used in different ways to how maybe we’ve traditionally seen them, in new and emerging roles. Some of those roles include more independent prescribing pharmacists, pharmacists that are working across clusters, and also pharmacists that are working in NHS 111, out of hours, in the clinical hub.”<sup>11</sup>

**24.** In October 2016, the Welsh Government reconfirmed their commitment to the community pharmacy sector as a fundamental part of a strong primary care service in Wales.<sup>12</sup> Suzanne Scott-Thomas, Chief Pharmacist, Cwm Taf University Health Board suggested that :

“I think we have a real opportunity in Wales at the moment. We have taken a very brave decision, perhaps, to change the community pharmacy contract, but I think the right decision. We are able to divert

---

<sup>11</sup> RoP, 19 June 2017, Paragraph 28

<sup>12</sup> Welsh Government, **Written Statement**, 10 April 2017

the energies of community pharmacy away from just the supply systems to more patient-facing and clinical services.”<sup>13</sup>

## Choose Pharmacy and Independent Prescribing

**25.** Community pharmacies play a key role in supporting patients to manage their medicines without accessing a GP or other NHS services. Choose Pharmacy is a scheme aimed at diverting patients away from GP surgeries and hospital emergency departments, by using the community pharmacy as the first port of call for specific medicine-related needs. There are currently 716 community pharmacies in Wales.

**26.** The cost of providing the Choose Pharmacy service sits with the health boards, who can decide whether to commission the service from community pharmacies. Health boards decide which of the following Choose Pharmacy “modules” to commission:

- Common Ailments Service (CAS) – a service for patients to seek advice from a community pharmacist, rather than a GP, on specific minor conditions.
- Discharge Medication Review (DMR) – a review by community pharmacists of a patient’s medicines after their discharge from hospital, facilitated by access to electronic discharge information.
- Emergency Medicines Service (EMS) – a service to provide certain emergency prescriptions directly through a community pharmacy, rather than through accident and emergency or GP out-of-hours.
- Seasonal Flu Vaccine (SFV) – a service where community pharmacists provide the flu vaccine, rather than a GP.

**27.** The Committee has concerns that this is a limited list and that there is much more than could be achieved and undertaken by pharmacists. This would help promote the value pharmacists can add and maximise resources.

**28.** Independent prescribers are currently nurse/pharmacist/optometrist independent prescribers who are able to prescribe a wide-range of medicines to patients without first consulting a doctor. Independent prescribers can prescribe autonomously for any condition within their clinical competence. This means that

---

<sup>13</sup> RoP, 19 June 2017, Paragraph 412

patients no longer have to rely solely on a doctor or consultant to be prescribed certain medications.

**29.** The Committee questioned witnesses about the funding of Choose Pharmacy and independent prescribing and found the scheme to be broadly welcomed. Dr Carwyn Jones said:

“There have been no issues at all. They do and will have to increasingly accept a multi-professional general practice team, and the more people we can help and mentor to do that—. They will need to have skills in community medicine in terms of GP support, and there may be areas where that support is stretched, but investing a little bit of our time in developing a team is what GPs have always done, and hopefully it’s a success of independent contractors.”<sup>14</sup>

**30.** During the Committee’s visits to GP surgeries and Pharmacies, we found there to be a positive and close working relationship between GP’s and pharmacists. We asked witnesses whether this was representative of across Wales. Mark Griffiths, Chair of Community Pharmacy Wales, stated:

“We like to work as closely as we possibly can with the GP practices because, at the end of the day, my primary concern is patient care. So, if we work closely with the doctors, then the patient generally benefits from that.”<sup>15</sup>

**31.** Overall, the Committee heard positive evidence to support the better use of pharmacists in medicines management, and ensuring the best skills are utilised in the correct areas. However, we also received evidence which suggested that there are a number of issues which need to be considered around workforce planning and training to achieve this.

**32.** The Committee asked witnesses what change would be needed to enable better use of both independent prescribing. Judy Henley, Director of Contractor Services for Community Pharmacy Wales, suggested in terms of independent prescribing:

“...there are barriers to training huge numbers of pharmacists to get them to become independent prescribers, not because of the length, of course, but because of the mentoring model and the need to release

---

<sup>14</sup> RoP, 16 October 2017, Paragraph 80

<sup>15</sup> RoP, 19 June 2017, Paragraph 83

the pharmacist to attend the training, which obviously requires backfill and everything else as well.”

and

“... it also needs a GP to support, from a training and mentoring purpose. If you’ve got a GP practice that’s already struggling, and already under capacity to actually find a GP to support that process, it becomes a bit of a vicious circle.”<sup>16</sup>

**33.** Carol Shillabeer, explained that there was a need for more support and guidance to prescribers, as there are increasingly more independent prescribers who are not doctors. She added that Powys has:

“...got very good relationships with universities that deliver that programme for us and there’s a very good and quite strict mentorship arrangement in place for new prescribers that come forward. But there is more—just speaking locally, really—for us to do in supporting those prescribers and making sure they continue to feel confident, because as we change different models of care we’re not relying so much just on doctors prescribing. There’s a whole host of people who can.”<sup>17</sup>

**34.** The Committee want to see the pharmacy workforce being developed and stretched. We believe that action needs to be taken to develop the confidence of the profession to move forward with these new roles.

**35.** When asked whether sufficient work had been done to identify how the pharmacy workforce needs to be planned and developed in order to maximise its contribution, Cheryl Way, a Royal Pharmaceutical Society Board Member said that:

“I think more work needs to be done. ...It is actually very hard to know how many pharmacists are out there working at the moment, and, with all these new and emerging roles, it is causing gaps in other parts of the system.”<sup>18</sup>

**36.** The collation of such data would be beneficial in helping ensure that the correct training is available to deliver the Welsh Government objectives in medicines management. For example, given the drive towards independent

---

<sup>16</sup> RoP, 19 June 2017, Paragraphs 73 and 75

<sup>17</sup> RoP, 19 June 2017, Paragraph 389

<sup>18</sup> RoP, 19 June 2017, Paragraph 30

advisors, Cheryl Way raised concerns that there are no facilities for training large numbers of independent prescribing pharmacists. Elen Jones highlighted:

“We currently have around 10 per cent of pharmacists in Wales that are trained as independent prescribers—I think it’s 287 independent prescribing pharmacists—but whether they’re all getting to use that qualification is something different....It may be worth noting that for a pharmacist to become an independent prescriber, it just takes six months, because you already have that core expertise and knowledge. So, it would be a good way to get more people that are able to prescribe to be able to do more services in community and primary care and in hospitals.”<sup>19</sup>

**37.** A number of the cluster GPs that the Committee spoke to, raised concerns about the training and availability of pharmacists. Dr Darren Chant from Meddygfa Teifi, Llandysul said:

“I think in terms of training, we’ve sourced our own pharmacists from secondary care because they seem to have a better understanding, and perhaps a slightly different level of experience to what the retail pharmacists currently provide. So, if we want to increase the number of pharmacists that are available to primary care, perhaps there needs to be an investment in training, especially in the retail sector.”<sup>20</sup>

**38.** Dr Alun Walters, Clinical Director, Primary Care & Community Service, Aneurin Bevan University Health Board (ABUHB) told the Committee that:

“There isn’t that one size fits all. If you’re talking about training a GP, there’s a recognised selection criteria, there’s a recognised training course, there’s a recognised exit exam, there’s a recognised level of competencies. All of these extended roles will have massive variation from one practitioner to another, and it’s working with those competencies and developing them that’s the challenge with these new roles, really.”<sup>21</sup>

**39.** However, Andrew Evans, the Welsh Government’s Chief Pharmaceutical Officer, suggested that there was a lot of positive evidence that the Choose Pharmacy scheme was being increasingly utilised:

---

<sup>19</sup> RoP, 19 June 2017, Paragraph 45

<sup>20</sup> RoP, 16 October 2017, Paragraph 77

<sup>21</sup> RoP, 16 October 2017, Paragraph 180

“The evidence we’re seeing from Choose Pharmacy, and particularly from the common ailment service element of the Choose Pharmacy application, is that now well over 1,000 consultations are taking place in pharmacies across Wales every month under that scheme, and a high proportion of people who use that scheme report that had they not done so, they would have otherwise visited their general practitioner.”<sup>22</sup>

**40.** The Committee are unconvinced by this evidence, the 1000 consultations a month, equates to around 250 a week for all of Wales. We do not believe this is ambitious enough and the pace of change is insufficient. We want to see a pharmacy profession which is empowered and confident to lead the change. The Committee have identified a number of barriers to this around training, IT systems and the pharmacy contract and we are calling for the Welsh Government to set out its vision for how to utilise the pharmacy sector with the ambition and scale needed.

**41.** The Auditor General recommended that a national service specification could help health bodies plan the pharmacy resources they need to meet demand. Such a specification could standardise the descriptions of various pharmacy services and could set out estimates of the resources required to deliver these specific services.

**42.** The Committee agreed that the Choose Pharmacy and independent prescribers are good initiatives to utilise resources effectively and achieve maximum value and welcomes the Welsh Government acceptance of the recommendation.

**43.** However, we were surprised at the lack of available information about the actual number of pharmacists practicing in Wales. Given the changes to the pharmacy workforce, arising from schemes such as pharmacists, being directly employed by GP practices and the locum workforce, there are a large number of pharmacists outside of those directly employed in the managed sector and the community pharmacy bodies. The Committee believes this is important information in planning delivery and feeding into the specification, in terms of not only the numbers employed but also the roles they are undertaking.

**44.** The Committee was also surprised to find that there was no training plan for pharmacists given the importance that has been placed on their developing role by the Welsh Government. If pharmacists are to play a role in effective medicines

---

<sup>22</sup> RoP, 16 October 2017, Paragraph 303

management, the skillset required needs to be clear along with the relevant training being available.

**Recommendation 3.** The Committee recommends that the Welsh Government sets out a plan to maximise the use of pharmacy resource, including developing the modules for delivery in choose pharmacy and enabling independent pharmacists. This plan should build on the recommendations in the Royal Pharmaceutical Society report.

**Recommendation 4.** The Committee recommends that the Welsh Government develops a data management system to track the number of pharmacists working in Wales and the roles being undertaken. This can also be utilised to plan training needs and requirements. Consideration should also be given to extending this to include information on wider pharmacy staff such as technicians who also have evolving roles which may impact on the training needs of the sector

### **Making best use of pharmacists in clusters: extended roles and preventing demand in GP surgeries**

**45.** In addition to utilising the opportunities within the Choose Pharmacy scheme and through independent prescribers. The Committee heard evidence about the role of pharmacists in primary care clusters, and how this can help with medicines management.

**46.** Following the 2010 publication from the Welsh Government “Setting the Direction”,<sup>23</sup> the seven health boards across Wales have created “primary care clusters” – 64 groups of neighbouring GP practices and partner organisations which provide services for their local populations of between 30,000 and 50,000 people. The cluster design promotes joint working across practices and the integration of primary care services with key partners such as the Ambulance Trust, Local Authority and Third Sector. Clusters also have a key role in supporting local health needs assessments, allocating appropriate resources and forecasting the potential future demand on primary care.<sup>24</sup>

**47.** Dr Andrew Goodall explained how health boards have utilised their own health board pharmacists to carry out medicines reviews or practices or different choices by different GPs within those arenas, and building on this by using the approach on:

---

<sup>23</sup> Welsh Government, Setting the Direction, 2010

<sup>24</sup> **Public Health Wales. Developing primary care in Wales**



“...clusters across Wales—so, the breaking up of Wales into these 64 general areas—and have seen a real requirement and request from GPs for more support on the pharmacy and prescribing side. So, just as an example, over the last 12 months or so, although we have put some additional pairs of hands in and we’ve used some of the central funding for this, we’ve seen now up to 100 pharmacists who are actually employed as extra pairs of hands within the cluster models. That means that they can give general support based on local advice and analysis of relevant areas, but also give advice around patient care and treatment as well.”<sup>25</sup>

**48.** The Committee heard a lot of positive evidence about the work of clusters in medicines management. For example, Ms Vincent explained that the use of the pharmacists within the clusters to take on roles that have been historically done by GPs is proving to be prudent because:

“They are undertaking a large amount of the reauthorisations on behalf of GPs, and have been shown to actually deprescribe—so, actually stop medicines that aren’t needed. They’re four times more likely—that’s certainly our local experience—to stop a medicine than in previous reviews. So, I think these cluster pharmacists have got an expanding role in terms of how we manage the medicines bill in terms of getting value for it, but also stopping things that are no longer needed.”<sup>26</sup>

**49.** Dr Carwyn Jones from Furnace House Surgery, Carmarthen, told the Committee that the cluster model had allowed GPs within the cluster to focus on patients whose chronic disease management needs the focus of GPs as the pharmacists are able to do the medicine reviews and other checks, such as asking about diabetes or a blood pressure check:

“An example, again, last Friday, the pharmacist did about 40 of those interventions for me that morning, and I know that I would not have been able to allow—. I wouldn’t have had time to do my afternoon visits before afternoon surgery had she not done that. So, I was able to give continuity of care and do an appropriate piece of work last Friday afternoon, because the two pharmacists—the cluster and the practice pharmacist—that morning had cleared these tasks, which needed professional knowledge ... . And, in the old days, I’ve said, ‘Well, GPs need

---

<sup>25</sup> RoP, 6 March 2017, Paragraph 94

<sup>26</sup> RoP, 19 June 2017, Paragraph 416,

to do that'. Well, then nurses did it and now, I think pharmacists have got a great role in doing that."<sup>27</sup>

**50.** Within the Aneurin Bevan University Health Board, clusters have been renamed neighbourhood care networks (NCNs). Eryl Smeethe, Pharmacist and Neighbourhood Care Networks Lead Torfaen North, ABUHB said the NCN pharmacists were

"...diverting patients from GPs with medication reviews, polypharmacy reviews; they are going out to housebound patients and going into care homes; and they are running clinics. The clinics that I'm aware of: they're doing respiratory reviews and inviting patients in to see if they can step patients down or whether they're being treated appropriately. I think with the NCN pharmacists, because their consultation time is longer than that of the GP, they can give a dedicated session to reviewing the medication and, hopefully, the patient will have an increased quality consultation with them because it's so dedicated, and, hopefully, the patient will be more satisfied because of that."<sup>28</sup>

**51.** Dr Darren Chant from the Ceredigion cluster echoed the comments from colleagues about the valuable work the cluster pharmacists can do, citing how they had used them as part of a frailty project, undertaking medicine reviews within home and residential home settings, where they were seeing far more patients with complex needs. He highlighted that the main challenge was:

"... that they're being funded by cluster moneys and we're only able to appoint, really, on short-term contracts, because we're not convinced that the money will be rolled over into future years. We continue to be at risk of losing our pharmacists, these really well-qualified people reviewing our medications, because they may go to other practices, they may go back to the health board, or they may choose to take up posts in the regional sector."<sup>29</sup>

**52.** Although, conversely Dr Alun Walters suggested:

"... one of the strengths is when the cluster pharmacist then becomes directly employed by the practices. That's a sustainable model. Otherwise, they kind of sit on the cluster's books as it were, and we

---

<sup>27</sup> RoP, 16 October 2017, Paragraph 32

<sup>28</sup> RoP, 16 October 2017, Paragraph 161

<sup>29</sup> RoP, 16 October 2017, Paragraph 41

can't move forward. Where it's worked well is where they've been trained, they've had a lot of mentorship from the cluster, they've attained their independent prescribing because of that mentorship, and they've then gone off and become directly employed. That frees up that vacant slot then to repeat the process."<sup>30</sup>

**53.** Dr Alun Edwards, Ty Bryn Surgery, Caerphilly said that the use of cluster pharmacists had been a positive experience, but:

“In terms of evaluation of this role, I'm not sure it's been totally evaluated as yet. From my perspective as a GP, I think they certainly bring quality. Whether they reduce GP workload, I think is a moot point. As within all professions, there's a spectrum of ability. In terms of training for these roles, I know 1000 Lives are looking to develop a community of practice for these new roles, but there has been not a huge amount of training, and I think there's scope for improvement.”<sup>31</sup>

**54.** Andrew Evans told the Committee that the use of pharmacists in clusters has been an:

“...incredibly important innovation for us here in Wales. The appetite amongst clusters has been insatiable in some respects. We've seen a real drive for increasing the number of pharmacists there. There is a limited amount of evidence coming out of clusters that suggests employing pharmacists—so, this is based on work in one cluster in Bridgend—for every one hour of clinical pharmacist time you employ in a practice you can save around 25 minutes of general practitioner time.”<sup>32</sup>

**55.** The Committee welcomes the positive evidence it has heard relating to cluster pharmacists. The Health, Social Services and Sport Committee published a report on GP Clusters<sup>33</sup> in October 2017 which recommended that the Welsh Government has a clearer and more robust method for evaluating cluster work , which was rejected by the Welsh Government because:

“Our national plan for a primary care service for Wales is underpinned by existing evidence from the King's Fund that assessing population

---

<sup>30</sup> RoP, 16 October 2017, Paragraph 163

<sup>31</sup> RoP, 16 October 2017, Paragraph 168

<sup>32</sup> RoP, 16 October 2017, Paragraphs 305 and 306

<sup>33</sup> National Assembly for Wales, Health, Social Services and Sport Committee, **Inquiry into Primary Care: Clusters**, October 2017

need and planning and delivering care to meet that need is most effective when done at a very local level of between 25,000 and 100,000 population. The OECD 2016 review of UK health systems and the interim report from the Parliamentary Review of health and social care provide further evidence of the value of cluster working.

To measure the impact of local collaboration on the health and wellbeing outcomes of their populations, clusters can use the results of evaluation of their local initiatives and the new nationally agreed set of quality and delivery measures for primary care. I expect this information to provide a reliable indication of the value of clusters. Sharing this information will help inform and justify future plans at cluster and health board level across Wales."<sup>34</sup>

**56.** We believe that given the increasing role of clusters, there is a need for an evaluation of cluster pharmacists. We are concerned that the current funding model does not provide enough certainty for clusters, and there is a clear need for this model to be given a more sustainable footing if it is to develop to its full potential. To which end we believe this evaluation should consider the funding model and recruitment model for pharmacists within the cluster model. This should help to establish the value and sustainability of the cluster model.

**Recommendation 5.** The Committee recommends that the Welsh Government undertake an evaluation of cluster pharmacists, which evaluates the funding model and recruitment model for pharmacists within the cluster model.

## The Pharmacy model

**57.** The primary care model in Wales is based around independent private contractors. This means there are currently over 700 pharmacy owners in Wales who are contracted to provide NHS community pharmacy services. GPs operate on a Practice based contract model where each practice is funded through three main funding streams: the global sum; the Quality and Outcomes Framework (QOF); and enhanced service payments.

**58.** The Committee was concerned that this contractor model results in different sets of professional vested interests who have to consider financial aspects rather

---

<sup>34</sup> **Welsh Government response.** Health, Social Care and Sport Committee report on the Inquiry into Primary Care: Clusters, October 2017.

than the patient needs, which would result in resources not being utilised to maximum effect.

**59.** Representatives from the pharmacy profession argued that the community pharmacy model had been working well. They highlighted the Powys model where GP practices have fully accepted pharmacists prescribing against a specified formulary. The GPs have been triaging patients to the community pharmacist to see those patients, which had resulted in a decrease of 21 per cent in the amount of appointments for more common ailments, which had freed up GP time for more complex diagnosis.

**60.** The Committee welcomes the use of pharmacists to carry out this prescribing, but are still concerned that the pharmacy resource is not being utilised to maximum effect. Mark Griffiths suggested that there may be a lack of understanding about what can be delivered by pharmacists and:

“As that develops I’m hoping that within the primary sector it could well be that the GPs would understand that there would be more and more use to be made of independent prescribers. I think at the moment it is difficult for GPs in busy practices to understand what a pharmacist independent prescriber can do for them, and that’s the issue at the moment, I think.”<sup>35</sup>

**61.** The Committee are concerned that this is illustrative of a friction within the system. It should be clear what the value of a pharmacist can add, and this needs to be recognised by everybody involved.

**62.** In addition to potentially creating conflict between GPs and pharmacists as to who would be responsible for delivering services, the Committee also explored whether the contractor model resulted in a potentially perverse incentive for pharmacists to prescribe, as this is how they generate income. Judy Henley set out that to address this some health boards have not dispensed schemes which is:

“...a similar process to that which repeat dispensing would use anyway, where you double-check with the patient whether they definitely need everything and how many they’ve got at home, all the time. So, it increases workload from the pharmacy perspective, but they get financially rewarded for taking part in that service. But that’s not widely available in every health board across Wales.”<sup>36</sup>

---

<sup>35</sup> RoP, 19 June 2017, Paragraph 67

<sup>36</sup> RoP, 19 June 2017, Paragraph 274

**63.** The Committee found a mixed picture in relation what was happening with non-dispensing schemes across the health boards, for example Cwm Taf UHB have had one for a number of years, while Abertawe Bro Morgannwg UHB do not have one. Judith Vincent, ABMUHB, suggested that there were going to be changes to the community pharmacy contract, which would take it away from an item-based remuneration, over a five-year period, to a more quality based system.

**64.** The Committee heard evidence about “repeat dispensing”, which is an essential service that every pharmacy has to provide, but which is underutilised in Wales. This is where the GPs can prescribe in batches of prescriptions of anything up to a full year’s worth of medication and that batch then stays with the pharmacy. One of the requirements of the service is that pharmacists check with the patient whether they require all of the items listed on the prescription each time they receive their medication. When questioned about why this was underused, Judy Henley suggested that:

“Partly because it requires workload in putting it in place to start with. So, GPs have to put the patients on to that service to start with, which requires significant work upfront, but then saves them work down the line. It is undergoing a bit of a relaunch at the moment with more materials, which will go out to all GP practices and to all community pharmacists, to actually help them to support patients in going onto that service, but it’s something that we’ve had as part of our contract since 2005. So, it is something that we can do that will actually help to potentially reduce waste.”<sup>37</sup>

**65.** Dr Carwyn Jones told us that while the process is now driven in a very patient centred way and that a lot of the community pharmacists are excellent, having pharmacists with a quantity-based contract:

“...does cause difficulties. I’d much rather we think about them having the quality contract, including, for example—. We have a prescribing incentive scheme for GPs. Maybe we should have an incentive scheme for them not to dispense, so that would be driving quality rather than quantity.”<sup>38</sup>

**66.** The Committee heard that there are challenges for pharmacist to not dispense certain items as they will not always know what the patient requires, particularly if the patient is not collecting the prescription themselves.

---

<sup>37</sup> RoP, 19 June 2017, Paragraph 268

<sup>38</sup> RoP, 16 October 2017, Paragraph 23

Pharmacists ask patients to check prescriptions before they leave the pharmacy because as soon as they leave the pharmacy with the medication it cannot be reused should a patient return if it was not required, as pharmacists are not permitted to legally re-dispense medicines.

**67.** The Committee questioned witnesses about whether a move to pharmacists being directly employed by the NHS instead of the independent contractor model was a positive one. Allison Williams suggested that “there’s room in the system for a mixed economy”. She felt that the independent contractor model had worked well in many ways, but as the system becomes:

“...more sophisticated in terms of the outcomes that we’re looking for through independent contractor contracts, and as was alluded to earlier, moving from a numbers-based incentive scheme to a quality outcomes-based incentive scheme, that will undoubtedly strengthen the independent contractor model in community pharmacy. ...But actually looking at directly employed pharmacists working as part of the primary and secondary care system, as Suzanne has described, is a real strength. It’s a strength, actually, that’s probably unique to Wales because of our integrated healthcare system. We would consider that to be a real advantage.”<sup>39</sup>

**68.** Andrew Evans told the Committee that there is a professional argument against the nature of perverse incentives within pharmacies and also as the vast majority of community pharmacists are employees there is not the financial incentive to grow volume. He told the Committee:

“...the perception is the incentive. But, in reality, several factors would lead us to conclude that it—. Why would there be an incentive for an individual who is paid on a salary basis to increase the number of prescriptions they dispense when that’s more workload for them with less return on it?”<sup>40</sup>

**69.** However, he did accept that:

“I think there’s an argument for us understanding to what extent pharmacists are able to influence prescribing volumes and whether those incentives actually play out.”<sup>41</sup>

---

<sup>39</sup> RoP, 19 June 2017, Paragraph 404

<sup>40</sup> RoP, 16 October 2017, Paragraph 293

<sup>41</sup> RoP, 16 October 2017, Paragraph 299

**70.** The Committee remains concerned that the current contract system is based on quantity of prescriptions rather than a quality based model. This creates a system which does not encourage pharmacists to consider whether it is necessary to dispense a prescription, which should be the aim to achieve the stated goal of increasing medicine management.

**Recommendation 6.** The Committee recommends that the Welsh Government amends the Community pharmacy contract to achieve the necessary changes to release the full potential of the pharmacy sector and realise the aim of moving from a quantity to a quality based set of arrangements, and implementation timescales.



## 4. Prudent prescribing

**71.** A written statement from the Welsh Government sets out the principles of prudent healthcare which states that any service or person providing care should:

- Do no harm. The principle that interventions which do harm or provide no clinical benefit are eliminated;
- Carry out the minimum appropriate intervention. The principle that treatment should begin with the basic proven tests and interventions. The intensity of testing and treatment is consistent with the seriousness of the illness and the patient's goals;
- Organise the workforce around the "only do, what only you can do" principle. The principle that all people working for the NHS in Wales should operate at the top of their clinical competence. Nobody should be seen routinely by a consultant, for example, when their needs could be appropriately dealt with by an advanced nurse practitioner
- Promote equity. The principle that it is the individual's clinical need which matters when it comes to deciding NHS treatment;
- Remodel the relationship between user and provider on the basis of co-production.<sup>42</sup>

**72.** These principles all have an impact on prescribing and medicine management. The Auditor General found that health boards and GPs have worked together to focus on prudent prescribing and have secured cost reductions, as well as improvements to patient safety and quality of care (these findings are described throughout the Auditor General's report (Paragraphs 2.15 to 2.35)).

**73.** However, the Auditor General also found that there is scope for further improvement. His report highlighted potential for around £8.3 million in savings through improved prescribing practices and the Welsh Government has estimated that around £10 million in possible savings is available by reducing wasted medicines (see paragraphs 2.27 to 2.28 in the Auditor General's report).

**74.** The Auditor General recommended that health bodies develop targeted action plans to achieve cost and quality improvements in primary and secondary

---

<sup>42</sup> Welsh Government **Written Statement**, 11 July 2014

care, in line with the prudent healthcare principles (Recommendation 5a). The report also included a recommendation for the Welsh Government to work with health bodies to develop a national plan for reducing wasted medicines (Recommendation 5d).

**75.** As part of its call for evidence from the public to support this inquiry, the Committee has heard about examples of patients automatically receiving repeat medicines even though they have already agreed with their GP and pharmacist that certain items are no longer needed to be prescribed. Once these items are taken away from the pharmacy, they cannot be returned and re-used, and are therefore wasted.

**76.** The Committee was interested in the evidence from Suzanne Scott-Thomas about emerging innovations to address some of these issues. She explained that “smart packs” are beginning to emerge which:

“... can tell you whether they’ve been opened or not, or whether they’ve been stored in, say, the correct temperature. Because if they were left out today, perhaps, we’d find that they probably wouldn’t be fit for purpose with the heat et cetera. So I think with emerging innovations and technology, there will come a time when we will need to review that legislation and regulation, because packs will become—we’ll be able to tell whether they’ve been kept at the right temperature and humidity, or whether they’ve been tampered with.”<sup>43</sup>

**77.** It is important to note, however, that health bodies’ efforts to reduce the total cost of medicines is complicated by fluctuating drug prices, rising demand for certain medications and the frequent emergence of new and expensive medicines (see paragraph 2.20 in the Auditor General’s report).

**78.** The Welsh Government’s Efficiency, Healthcare Value and Improvement Group has agreed that a key area of work in 2017-18 will be the development of an all-Wales approach to cost and quality improvement in medicines management in primary and secondary care. The Welsh Government has indicated that it will work with NHS bodies to develop and implement a clear national plan aimed at reducing medicines waste. Work on this will take place during 2017-18 with the aim of producing a time-bound plan by March 2018. In its response the Welsh Government indicates that it will:

---

<sup>43</sup> RoP, 19 June 2017, Paragraph 428

“...encourage health boards to implement evidence based approaches which reduce medicines waste. These will include implementing improved repeat prescribing such as those which have been tested through the Prudent Prescribing Implementation Group or evaluated in other parts of the UK.”<sup>44</sup>

**79.** The Committee is concerned about the levels of medicine wastage in the system which could be preventable. While we understand the legitimate concerns around medicine safety for re-utilising medication, we cannot accept that nothing can be done. We challenge the Welsh Government to look for smarter approaches and to ensure that it is fully ready to utilise emerging technologies.

**Recommendation 7.** The Committee recommends that the Welsh Government plans for the emerging technologies in prescription packages facilitating the use of unopened medication when it does not compromise patient safety including the necessary legislative changes that may be needed, to ensure maximum advantages for any savings can be achieved.

## Medication and Prescribing Errors

**80.** The Auditor General’s report found that while estimates of the rate of prescribing errors vary greatly, up to 50 per cent of hospital admissions may involve a prescribing error. The report suggests there is a need to do more to prevent medication-related admissions (MRAs) to hospital but that issues with the coding of hospital admissions make it difficult to quantify the true extent of the problem. As a result of this poor data it is difficult to target the root causes of these admissions. The Auditor General therefore recommended that the Welsh Government, supported by 1000 Lives Improvement, should work with pharmacy teams, clinical coding staff and clinicians across Wales to develop a programme aimed at identifying and preventing MRAs (Recommendation 8).

**81.** The Committee explored with witnesses the accuracy of data capturing medicines-related admissions and whether this needs to be improved. Allison Williams advised it was difficult as medical staff are reliant on the information provided by patients but:

“... this makes the medication review system outside of hospital the most important factor in ensuring people are taking their medications correctly. There’s a difference between a medication error and a

---

<sup>44</sup> Written evidence, **PAC(5)-04-17 Paper 9**, 30 January 2017

prescribing error; prescribing errors are much more easily identifiable because you have an audit trail between the medicine that an individual was prescribed or dispensed, and an original prescription. Those are, thankfully, very, very rare because of the robust checks in the system. I think the more difficult issue is compliance with the prescription in the first place, causing iatrogenic problems and therefore hospital admissions.”<sup>45</sup>

**82.** The Committee questioned the Director General/NHS Chief Executive about the lack of robust data for medication-related admissions. Dr Andrew Goodall explained that they try to use international evidence, which refers to likely admissions for medication errors and issues, which is where the 6 per cent figure in the Auditor General’s report originated. However, Dr Goodall agreed that:

“There’s a huge disconnect between the international classification system that is in place, which the NHS uses, which is basically focused on the procedures that are undertaken and the diagnosis. What they’re not trying to do is actually have the underpinning messages about the medication error. But I do think that there is more that we can do there and there are certainly other classification systems that can act in support of this to see whether we can make sure that this is a robust part of the data.”<sup>46</sup>

**83.** Andrew Evans explained that:

“The reality is when people are admitted, identifying that it’s a medicines-related admission is not apparent, or is rarely apparent at the point of admission and the work you have to do to try and get to a figure of 6 per cent, identifying all your admissions, is disproportionate.”<sup>47</sup>

**84.** He stressed that there was a lot of good work going on in Wales “not focusing on the admission itself but focusing on the quality use of the medicines that are most likely to be implicated in an admission”.<sup>48</sup>

**85.** The Committee questioned witnesses on the involvement of the academic community in planning at the clinical interface about how to maximise medical

---

<sup>45</sup> RoP, 19 June 2017, Paragraph 453

<sup>46</sup> RoP, 6 March 2017, Paragraph 201

<sup>47</sup> RoP, 16 October 2017, Paragraph 202

<sup>48</sup> RoP, 16 October 2017, Paragraph 203

safety. The Welsh Government confirmed that there was an active engagement with academics and that the 1000 Lives team would give:

“...a focus—national, across organisation, at the front-line level—which gives us a beat about the approach that this will look to do and some advice around things like the classification mechanisms. We would see that all as part of the same work, and, yes, we’ll be making sure the academic mechanisms are lined up as well.”<sup>49</sup>

**86.** The witnesses from the university health boards highlighted that work was in progress to make the most of academic linkages. For example Betsi Cadwaladr UHB has a Bevan exemplar pharmacist undertaking work on medicines-related admissions. Judith Vincent, ABMUHB, told the Committee that Professor Routledge, a clinical professor at Cardiff University, had “set up a patient safety-orientated group”<sup>50</sup> with a number of experts.

**87.** The Committee is keen to ensure that the linkages with the academic community in Wales are being utilised to maximum effect, to help develop solutions to medicine management, and in particular, medicine related admissions where the challenges of collecting robust data are significant.

**Recommendation 8.** The Committee recommends that the Welsh Government investigates ways of harnessing the academic expertise in Wales to understand the scale of Medicine Related Admissions and how to reduce them.

## Automated Ward Vending

**88.** Automated dispensing systems for medicines within the Secondary Care setting have the potential to optimise medicines management, improve efficiency, maximise resources and safeguard patient safety.

**89.** The Auditor General recommended that:

“Each health body should develop a time-bound plan for improving storage and security of medicines on hospital wards, including specific consideration of the benefits of implementing automated vending machines. (Recommendation 2b).”<sup>51</sup>

<sup>49</sup> RoP, 6 March 2017, Paragraph 210

<sup>50</sup> RoP, 19 June 2017, Paragraph 460

<sup>51</sup> Auditor General for Wales Report – **Managing medicines in primary and secondary care**, December 2016, Recommendation 2b

**90.** The Welsh Government's response to the Auditor General's recommendation indicated that the Chief Pharmaceutical Officer for Wales would be working with NHS bodies to complete a review of the use of automated ward vending machines to identify a prioritised list of sites where automated vending should be implemented. This work was due to be completed by June 2017.

**91.** The Committee questioned the Welsh Government about why only 8 per cent of wards have automated ward vending machines. Dr Goodall explained that:

"Some of it is down to environment, because wards are going to have to be adapted for that. Often it becomes part of the local approach towards refurbishment. Sometimes it's down to affordability locally."<sup>52</sup>

**92.** Andrew Evans highlighted that since the Auditor General's work, there has been investment in this area, and the coverage of wards is now "around 25 per cent". However, when pushed as to whether there was a target figure for ward coverage, he said:

"I think that's very difficult to predict. It really does depend on the particular approach on individual wards. So, if we're using patients' own medicines, which I think is something that we should be driving towards—the patients who can use their own medicines on a ward bring them in with them and use them themselves whilst they're in-patients—then automated ward vending isn't necessarily the solution for those wards. So, without looking at the detailed practices across all wards, it's hard to say."<sup>53</sup>

**93.** Allison Williams explained that:

"I think that's back to the point I was making earlier in terms of ward based—at the moment the jury is out in terms of us getting this balance between the automated dispensing of medicines on the ward, versus encouraging people to have their own medicines and take responsibility for their own medicines. So, that is something that we're going to have to come to a view on, having reviewed all of the options around that, probably within the next 12 months. But what we've done is we've targeted the high-risk areas, and the areas where

---

<sup>52</sup> RoP, 6 March 2017, Paragraph 79

<sup>53</sup> RoP, 6 March 2017, Paragraph 82

implementation would be quickest and most effective, and that has been achieved across all of the health boards.”<sup>54</sup>

**94.** The Committee believes there are clear clinical benefits to having automatic machines on some wards. The Committee are concerned that the Welsh Government has indicated that a review of the use of automated ward vending machines would be undertaken to identify a prioritised list of sites where automated vending should be implemented, before they have undertaken a robust assessment to establish whether they would be a benefit in a certain percentage of wards.

**Recommendation 9.** The Committee recommends that the Welsh Government provide an update on the automated vending evaluation work which was due to have been completed by June 2017.

**Recommendation 10.** The Committee recommends that the Welsh Government co-ordinates a piece of work to share best practice from Health Boards relating to automated vending to help inform future decisions on medicine storage approaches.

## Prescribing medicines that can be bought over the counter

**95.** When the Committee undertook a number of outreach visits, Members heard a lot of suggestions about how the prescription of over the counter medicines was an area which should be looked at in the wider considerations around medicine management.

**96.** Members heard that Stanwell Surgery in Penarth have taken a proactive approach to not prescribing items which can be purchased easily and at a reasonable cost over the counter. This initiative has come from a Cardiff and Vale University Health Board direction, but has not been taken up by all the surgeries in the Health Board area. To help with the implementation of this policy, the surgery has produced a letter to give to patients, along with a letter from the Health Board - which can provide some additional answers to the potential questions about why some items are not prescribed.

**97.** This approach was broadly welcomed by the patient representatives at the meeting in Penarth but some concerns were expressed about being prescribed items which could be easily brought. The practitioners present did however state a note of caution that items are not just prescribed to save a patient money, in

---

<sup>54</sup> RoP, 19 June 2017, Paragraph 481

some instances these seemingly easily purchased drugs are included to ensure that patients are aware they need them, and that they are being taken.

**98.** At the visit in Llanelli, 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 food products, have been stopped. However, participants raised concerns that such an approach would have a negative impact on the more vulnerable in society who may be unable to afford these products and be forced to go without.

**99.** This was also raised by the participants in Ebbw Vale, who told Members that lots of patient have drugs prescribed on a historic repeat prescription and don't realise that they can buy some of them, for example in the case of basic painkillers. It was felt that there was a need for consistency amongst those prescribing, and at present the message is not really targeted properly. It was noted that a lot of this particular surgery's patients are unable to afford to purchase these available medicines due to low incomes and reliance on benefits.

**100.** Dr Alun Walters told us that there were additional costs associated with a prescription:

“...if it goes through a high-street pharmacy, through a prescription, there are all sorts of costs incurred from the GP side of things, through to the pharmacy—dispensing fees and all these other things—on top of whatever the ticket prices are, which might be well above what people would pay in a supermarket chain for it.”<sup>55</sup>

**101.** Dr Carwyn Jones highlighted as well as the cost issue, there is also:

“...the issue about taking care of your own health, as we look at that as of increasing importance for Wales, because our health has a number of challenges. People in Wales love the NHS, and quite rightly so. They have a very personal relationship with it, which, obviously, we want to maintain. But, to be responsible, people in that organisation, they should be doing as much as they can without having to involve the professionals and incur those costs.”<sup>56</sup>

**102.** However, the issue of not prescribing over the counter drugs is not as straightforward as not providing the medicine. Dr Alun Edwards told the Committee that:

---

<sup>55</sup> RoP, 16 October 2017, Paragraph 194

<sup>56</sup> RoP, 16 October 2017, Paragraph 90



“It’s patient driven, by patient expectation. I don’t know whether there would be variation in terms of—. I practise in a—. Parts of my practice area are quite deprived, and I see—you will see patients who come in just purely for a prescription where the medication is available over the counter. It’s a difficult conversation. There is patient expectation. How you phrase it: ‘Are you aware this is available over the counter?’ ‘Yes, but I’d like it anyway’—or some patients will take that message away and go to the chemist, and some of them don’t actually expect you to prescribe. There’s huge variation.”<sup>57</sup>

**103.** Professor Chris Jones, the Welsh Government’s Deputy Chief Medical Officer, explained that there were a number of reasons for these prescriptions, which means it is not straightforward as it may seem. For example in terms of paracetamol:

“... prescribing would be most prevalent in either children or in the very elderly. If you consider both groups, then the cost is potentially much more than it appears. So, for children, children would generally need some liquid preparation of paracetamol, and that doesn’t cost peanuts, and actually can be quite expensive. For the very elderly, who may have arthritic pain, paracetamol prescribed at two tablets four times a day would mean they would have to go to buy their 32 tablets seven or eight times during every month, which, again, is quite a personal cost, because there is a limit to the number of paracetamol tablets you can buy.”<sup>58</sup>

**104.** Andrew Evans assured the Committee that there were controls over the cost of medicines within the NHS, which make direct comparisons with supermarket pricing:

“... What we have in terms of medicines pricing across the UK are system-wide controls. So, we tend not to apply controls at individual product level. What we apply is a control on the amount of profit that pharmacy contractors are able to make from purchasing medicines. That means that whilst on occasion a pharmacy might get paid a certain amount for dispensing a medicine, and that might look higher than the price you might be able to buy that in a retail environment for, it all contains a strictly controlled level of profit that means were they being paid too much for that medicine, it will be being clawed back

---

<sup>57</sup> RoP, 16 October 2017, Paragraph 216

<sup>58</sup> RoP, 16 October 2017, Paragraph 327

out of the system somewhere else. So other medicines would be paid at a lower rate.”<sup>59</sup>

**105.** NHS England undertook a consultation on reducing prescribing of over-the-counter medicines for 33 minor, short-term health concerns between December 2017 and March 2018, as in the year prior to June 2017, the NHS in England spent approximately £569 million on prescriptions for medicines which can be purchased over the counter from a pharmacy and other outlets such as supermarkets.<sup>60</sup>

**106.** The Committee does not wish to comment on the Welsh Government’s policy of free prescriptions, which is outside the remit of the inquiry and the Committee. However, the system will work best where there is a degree of personal responsibility with regards to prescriptions, and the Committee believes that there would be a benefit to ensuring the information about what can be brought at a reasonable cost over the counter is clear in pharmacies and GP surgeries. Not only will this help to reduce cost, it will also have the benefit of saving professional time of GPs and pharmacists.

**Recommendation 11.** The Committee recommends that the Welsh Government identifies whether any lessons could be learnt from NHS England relating to guidance on items which should not be usually be prescribed and the potential savings this approach may deliver.

## Repeat Prescriptions

**107.** Research from the National Prescribing Centre suggests that around 80 per cent of all prescribing in primary care is repeat prescribing. The Auditor General found that, “if appropriate processes are not in place to manage and regularly review repeat prescriptions they can be a significant cause of waste”.<sup>61</sup>

**108.** All of the Committee Members had anecdotal evidence of constituents struggling to get items on repeat prescriptions, or ending up with stockpiles of medicines due to the repeat prescription system. This was echoed by Dr Carwyn Jones, who said:

---

<sup>59</sup> RoP, 16 October 2017, Paragraph 346

<sup>60</sup> NHS England: **Conditions for which over the counter items should not routinely be prescribed in primary care: A consultation on guidance for CCGs**

<sup>61</sup> Auditor General for Wales Report – **Managing medicines in primary and secondary care, December 2016**, Paragraph 2.28

“... I think we’d agree, because we all go to patients’ houses and we open cupboards and we have surprises. That’s an anecdote, but you speak to people and if you’ve got elderly family members yourselves you’ll see it, because of the complexity of getting the right amount of medication there all the time.”<sup>62</sup>

**109.** There are a number of different mechanisms for the management of repeat prescriptions including regular medicine reviews, and My Health Online (an online system for patients to manage repeat prescriptions). This is a system which allows patients to access the GP surgeries and book appointments, order repeat prescriptions and update general details. There are currently about 250,000 people registered on this system. This system allows for patients to select what medication they would like to receive as part of their repeat prescriptions.

**110.** Andrew Evans highlighted that it is a complex process, and that there is tripartite relationship, with the patient, pharmacy, and the prescriber, who all have responsibilities to make sure repeat prescribing is done effectively. He added:

“We are working through something called the prudent prescribing group to consider various models for repeat prescribing systems, and once we have a clearer sense of where the evidence lies in that, we’ll be working with health boards to see them implemented to try and eradicate the problem you describe.”<sup>63</sup>

**111.** Much of the evidence we heard relating to repeat prescriptions, is anecdotal and it is very difficult to quantify the levels of waste generated through the repeat prescription system. Dr Alun Walters highlighted that is difficult to define the levels in the general population, but that the Aneurin Bevan University Neighbourhood Care Network (NCN):

“...has done a recent bit of work in identifying wastage within care home settings—this demonstrated quite a lot of wastage—and has worked with the care homes to alter the way they do their repeat ordering, which has resulted in quite significant demonstrated savings over the last six months in that. So, that’s a defined piece of work that was able to be done in a defined setting.”<sup>64</sup>

---

<sup>62</sup> RoP, 16 October 2017, Paragraph 64

<sup>63</sup> RoP, 6 March 2017, Paragraph 108

<sup>64</sup> RoP, 16 October 2017, Paragraph 138

**112.** Dr Alun Edwards suggested that anecdotal evidence suggests the repeat ordering service available in community pharmacies can result in lots of waste, but that AMUHB is considering ways to alter this including:

“... where the medication can only be ordered via the GP surgery, and we use IT solutions like My Health Online to do that, or just ordering only via the surgery. So, that’s something we’re actively looking at, at the moment in some practices.”<sup>65</sup>

**113.** Dr Darren Chant expressed some caution relating to the over-reliance on IT systems:

“I think if somebody’s ordering medication without any contact with another human being, then that medication may be meaningless to the patient. If they’re questioned as to, ‘Do you need this tablet this month or this inhaler this month, Mrs Jones?’, I think that will focus the patient a little bit more as to whether the medication is needed, and it doesn’t become purely a tick-box exercise. So, education and human contact, rather than automation.”<sup>66</sup>

**114.** The need for greater communication between primary care and secondary care was highlighted as a key issue in managing repeat prescriptions. Dr Carwyn Jones told the Committee that the clusters are working at the point of discharge:

“... to have accuracy. The accuracy of prescribing between primary and secondary care is critical, so they’re doing medicines reconciliation. I think it’s early days, really, to see—. That’s not been really hugely on their agenda up to this point, if I’m honest. The main thing we’ve been doing at the moment is introducing them to a different working environment and starting to trust each other, mentor each other and support them. A significant amount of training is going into them as well. We haven’t, to be honest, really driven the wastage, and it’s commendable that we’re starting to look at that and we will be doing in future, certainly.”

**115.** Eryl Smeethe explained that the Gwent NCN were piloting a number of systems for reducing waste from repeat prescriptions, including removing the managed repeat system, which is where a pharmacy orders on behalf of the patient. She suggested that this system was problematic as:

---

<sup>65</sup> RoP, 16 October 2017, Paragraph 139

<sup>66</sup> RoP, 16 October 2017, Paragraph 28

“...although the pharmacy has to ask the patient, for each item, whether they actually need it or not, quite often this is done a month in advance when they’re collecting their previous month’s prescription. So, they’re anticipating what they will need in a month’s time. Quite often, they just say yes to everything because they’re not quite sure.”<sup>67</sup>

**116.** Another important element to addressing the issue of managing prescriptions and particularly repeat prescriptions, was the need for more direction and education. Dr Darren Chant suggested:

“Education should come through all levels of the service, really, from hospital discharge to community nurse review, to GP review, to pharmacy.”<sup>68</sup>

**117.** The Committee was encouraged to hear a number of examples of trials to reduce the wastage from repeat prescriptions. The challenges of repeat prescriptions is something, which is relayed to Assembly Members on a regular basis and needs to be addressed.

**Recommendation 12.** The Committee recommends that the Welsh Government produces a report on best practice on repeat prescription ordering by cluster groups within the care home settings to help inform policies and actions on repeat prescriptions.

**Recommendation 13.** The Committee recommends that the Welsh Government provides an update on the work of the prudent prescribing group in relation to its work on the various models for repeat prescribing systems in September 2018 to allow the Committee to monitor progress on this.

---

<sup>67</sup> RoP, 16 October 2017, Paragraph 142

<sup>68</sup> RoP, 16 October 2017, Paragraph 67

## 5. Interface between primary and secondary care

**118.** The transfer of care from secondary care to primary care or primary to secondary, or even within primary care, is a potential risk around medicines management, which was highlighted in written evidence from the Royal College of General Practitioners.<sup>69</sup>

### Discharge information from secondary to primary care

**119.** The Auditor General's report found that the quality and timeliness of discharge information from secondary care to primary care could be an issue stating:

“Our survey of staff showed that 31 per cent of pharmacy staff and 27 per cent of doctors disagreed or strongly disagreed with the statement ‘The discharge information about patients’ medicines provided to GPs is of high quality.’ During our fieldwork we were also told that some discharge summaries can take a long time to reach the GP and some are difficult to read because they are handwritten. Electronic discharge summaries can be a solution to such issues as they involve computerised records being directly sent to GP systems. Across Wales, at the time of our local audit work just 34 per cent of wards produced electronic discharge summaries.”<sup>70</sup>

**120.** These findings were echoed by anecdotal evidence heard by Committee Members and at the stakeholder events, with reports of not enough information being available upon discharge from hospital quickly enough, lists of medication prescribed while in hospital not being provided and no indication of future need, diagnosis or more expensive drugs being prescribed by consultants. Judy Henley said the Choose Pharmacy platform will aid the pharmacies in getting the information quicker as:

“...one of the programmes on that platform means that we will be able to receive an electronic form of the discharge letter direct from the hospital, which means that we'll be able to see their information and be able to carry out that review without requiring the patient to walk in

---

<sup>69</sup> Written Evidence, **PAC(5)-26-17 Paper 1**, 16 October 2017

<sup>70</sup> Auditor General for Wales Report – **Managing medicines in primary and secondary care**, December 2016, Paragraph 3.19

with the information, which is a barrier, because when patients are being discharged from hospital, probably the last thing on their mind is telling their community pharmacist that they've been in.”<sup>71</sup>

**121.** There was particular concern expressed about the flow of information from secondary care to primary care. Dr Darren Chant said:

“I think the flow of information from primary to secondary care is much better than the opposite direction. It's very easy for GPs to provide very detailed referral letters both for outpatient appointments and acute admissions by just pressing a few buttons on our IT system, which is very well developed. We can give a list of all the medications, investigations and results in a letter with very little work. The flow of information from secondary care to primary care is the main issue that we have, and I think it's probably the main issue we have with prescription errors.”<sup>72</sup>

**122.** Andrew Evans highlighted the work undertaken by Welsh Government to address this at the interface through the roll out of the medicines transcribing and e-discharge system (MTeD) which has been rolled out in 5 Health Boards. This system provides for an electronic record of a patients medicine and summary of admission to be shared with the GP within 24 hours of discharge. He said that this was having a very positive impact on sharing information at the interface, and that along with sharing this information with GP surgeries, there was a move to sharing that information with community pharmacists. To illustrate its functionality he said:

“...in September [2017], I understand there were just over 9,000 electronic discharge letters shared with GPs across the five health boards I mentioned earlier through the MTeD system, and the number is increasing significantly. So, we've seen a more than doubling in Cardiff and Vale in the number of discharges sent electronically in the last 12 months, an increase of 50 per cent in Cwm Taf and, again, an increase of more than double in Betsi Cadwaladr health board”<sup>73</sup>

**123.** It is vital that there is effective communication between the interface between primary and secondary care. This information is key to effective

---

<sup>71</sup> RoP, 19 June 2017, Paragraph 99

<sup>72</sup> RoP, 16 October 2017, Paragraph 125

<sup>73</sup> RoP, 16 October 2017, Paragraph 368

medicine management. The Committee welcomes the roll out of the MTeD system, but believe this needs to be done with more consistency and urgency.

**Recommendation 14.** The Committee recommends that the Welsh Government evaluates the roll out of Medicines Transcribing and e-Discharge system to consider the progress and the benefits of this approach.

## Out-Patient dispensing in the community

**124.** In addition to improving the flow of information between secondary and primary care. The Committee explored the advantages and disadvantages of a move towards out-patient dispensing in the community, whereby rather than outpatients waiting for their medicines at hospital pharmacies, an outpatient prescription would be dispensed in their local community pharmacy.

**125.** There was a lot of support for this approach as it enables patient choice and may help to cut down on potential errors as pharmacies receive the information directly. Mark Griffiths, Community Pharmacy Wales, said:

“I firmly believe that when a patient leaves hospital, they should have a prescription that can be dispensed in the community pharmacy of their choice, because that means that it can tie in with the medication that they’re previously on so you can check that out. Also, you can do a discharge MUR on them straight away, and you have more experience of that patient than them coming out of hospital with the medication and then eventually it gets to the doctors, and then eventually we get the prescription a week, month, whatever later. I think the system, if that was in place, would cut down on potential errors, definitely.”<sup>74</sup>

**126.** It was suggested that there was a potential downside if the pharmacy did not have the medicine in stock immediately, but that any delay was likely to only be in the range of 12-15 hours. Cheryl Way, Royal Pharmaceutical Society Wales Board Member, stressed that:

“I don’t think we’ll ever be able to send all out-patients to community pharmacies. They have a choice to come to the hospital pharmacy, and some medicines are not available through community pharmacies and have to be dispensed in the hospital. There’s certainly a lot of clinical trials medicines and things like that that only go through hospitals, but

---

<sup>74</sup> RoP, 19 June 2017, Paragraph 125



I think all health boards are using it to a greater or lesser extent to improve patient choice.”<sup>75</sup>

**127.** The Committee considers that the move towards outpatient dispensing in those instances where it is appropriate, may help to reduce prescription errors and will help improve patient choice. As well as improving the patient choice this could also have a positive impact on hospital pharmacy waiting times too.

## The GP record

**128.** The Committee heard about how GP records may improve the flow of information and the patient experience. Dr Carwyn Jones told the Committee that while a GP record exists in primary care, the IT in secondary care is not at the same level, but he thought:

“...the public now expect us to be sharing that information on a need-to-know basis, and therefore it is a missed opportunity. Primary care’s got such good IT that we’ve just really been waiting 15 years for hospitals to catch up, and we don’t understand why that hasn’t been driven. .... But if you’re a patient and you have the checks and procedures to say, ‘Look, can I access that record?’ and there are checks and audit trails to do that only appropriately, I think the Welsh public will expect primary and secondary care prescribing to be on one clinical system.”<sup>76</sup>

**129.** The pharmacy professionals also supported this approach. Elen Jones told us that read-and-write access to the patient record or to the GP health record to enable pharmacists to get a clear picture of what medication has been prescribed to a patient:

“So, as a professional body, that is something that we are really driving behind: the need to get both read and write access to the record. My belief is that it should be that patient record and that they can give access to any healthcare professional that they think should have access to it, so that we can really know what we are supplying.”<sup>77</sup>

**130.** The Auditor General found some limitations with the GP record system in its current form, and suggested that:

---

<sup>75</sup> RoP, 19 June 2017, Paragraph 131

<sup>76</sup> RoP, 16 October 2017, Paragraph 124

<sup>77</sup> RoP, 19 June 2017, Paragraph 239

“Given the potentially significant time savings and safety improvements possible through the GP Record, both on the wards and in general practices, it is important that use of the system is expanded.”<sup>78</sup>

**131.** To address this, the Auditor General recommended that:

“R9: The GP Record allows authorised staff to access electronic information held by GPs about patients’ current medication. The system is currently available to a limited range of staff in hospital and in the community, and can only be used in hospital for patients admitted as emergencies. A barrier to expanding the use of the system is concern from GPs about the security and governance of sensitive information about their patients. The Welsh Government and NWIS should:

- a continue to work with GP representatives to ensure their concerns about information governance are addressed;
- b facilitate wider access to the GP Record so that all pharmacists and pharmacy technicians that deliver clinical services on the wards can access the system for patients who are admitted for an elective procedure, as well as those admitted as emergencies; and
- c facilitate wider access to, and use of, the GP Record in community pharmacies so that whenever it is clinically appropriate, patients can have their medicines managed in the community without accessing a GP or other NHS services.”<sup>79</sup>

**132.** The Committee would like to see access to the GP record rolled out across primary and secondary care. Given the incidents of medicine related admissions, this seems a prudent development, and allows the patient greater control of their information. This record may emerge out of the developments with the MTeD, but the Committee would welcome an update from the Welsh Government on the progress against the Auditor General’s recommendation.

**Recommendation 15.** The Committee recommends that the Welsh Government provide an update on the progress against the Auditor General’s

---

<sup>78</sup> Auditor General for Wales Report – **Managing medicines in primary and secondary care**, December 2016, Paragraph 3.6

<sup>79</sup> Auditor General for Wales Report – **Managing medicines in primary and secondary care**, December 2016, Recommendation 9

recommendation on the GP record and the other outstanding recommendations in the Auditor General's report.

## 6. Electronic Prescribing

**133.** Medicine management operates in a changing and evolving environment. There are a number of IT related solutions for prescribing in both primary and secondary care which may have a number of benefits in facilitating quicker, safer and cost-effective transfer of information.<sup>80</sup>

### Electronic prescribing in secondary care

**134.** In Welsh hospitals, the current prescribing process is paper-based. Prescribers in hospital write prescriptions on paper drug charts which pharmacy staff use to dispense the medicines. There has been a national plan to implement Electronic Prescribing and Medicines Administration (EPMA) system since 2007, with an initial aim to deliver this by 2010. The Auditor General found that while undertaking field work for his inquiry, pharmacy teams frequently expressed their frustration at the slow progress in implementing the roll out of an EPMA solution. The Auditor General recommended that the Welsh Government, NHS Wales Informatics Service (NWIS) and all health bodies should agree a detailed, time-bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery of the plan.

**135.** The Welsh Government's response to the recommendation shows that NWIS has now established the Welsh Hospital Electronic Prescribing and Medicines Administration Project. Work is ongoing to define the scope of the project and system requirements. Subject to the completion of a business case, Welsh Government expects the procurement of systems to be completed in 2018-19 with implementation beginning in the early part of 2019.

**136.** The Committee questioned the Director General/Chief Executive of NHS Wales about why it has taken so long to implement electronic prescribing. Dr Goodall acknowledged that there was a need "to move ahead with e-prescribing system in Wales",<sup>81</sup> but that it has taken time as it is "not merely about putting in a local system and switching it on. It is a process that is as much about change of behaviour of professionals as it is a safety issue".<sup>82</sup>

---

<sup>80</sup> Auditor General for Wales Report, **Managing medicines in primary and secondary care**, December 2016, Paragraphs 4.9 to 4.10

<sup>81</sup> RoP, 6 March 2017, Paragraph 10

<sup>82</sup> RoP, 6 March 2017, Paragraph 9

**137.** When pressed on the issue of the time taken to introduce this system, Dr Andrew Goodall said:

“I think partly because of all the other competing demands on other systems that we want to buy in other ways. So, as I said earlier, just listing off, we’ve invested and implemented in patient-management systems in a consistent way across Wales, radiology systems and GP systems. So, the pharmacy setting and e-prescribing is the next avenue. It would be wrong to say that there aren’t systems in place around pharmacies. They are supported and there is an infrastructure in place, but this is going for the next level of support around data and quality in terms of what’s happening. I think we did need elements of infrastructure, though, to be in place. So, I think it was right that we’ve had to prioritise other aspects to make sure that we’re in the best premise for this. As I said, as I came into my own role, it was to me quite clear that we needed to have a proper focus on this. I brought it through to the NHS board for that reason and have had the work in place over the last 12 months or so.”<sup>83</sup>

**138.** There was broad support for the suggested approach to rolling out a system for the whole of Wales. Ms Scott-Thomas, Cwm Taf UHB, explained that it was beneficial as it will be able to generate data that will give a better picture of medicines prescribing and:

“We don’t want each health board going and having their own discrete system, which we could be at risk of, and I think it is the way that they’ve taken in England. We want one system for Wales. So, when our medical staff and nursing staff move around the hospitals, if they’re experiencing different systems each time they move a hospital, that’s a risk. We want them to learn once and be able to move from hospital to hospital in a safe manner.”<sup>84</sup>

**139.** The Committee heard a number of concerns that the roll out of this system in a secondary care setting was about more than the introduction of an IT system, and would also involve a cultural shift. To address this, Cheryl Way, Royal Pharmaceutical Society Wales Board Member, explained that:

“... we have some change management people with NWIS who are working closely with us, which will help, and we’re engaging with all

---

<sup>83</sup> RoP, 6 March 2017, Paragraph 51

<sup>84</sup> RoP, 19 June 2017, Paragraph 507

the health boards, so at least they have an understanding of what's coming. Obviously, we have to go through a public sector procurement to actually buy the system, and we will be involving everybody in that specification and tendering exercise. We do have experience from other places in England and Scotland that are doing this already to learn from. There is quite a lot of information available out there, from the experience of other people in putting these in that we're reading up on and will use as part of the implementation."<sup>85</sup>

**140.** The Committee are concerned that there is little in the way of a plan for the cultural shift needed to deliver this vital system.

**Recommendation 16.** The Committee recommends that as part of the Welsh Government's commissioning and roll out of an new e-prescribing system, it develops a supporting plan of action to help achieve the cultural shift that needs to accompany the introduction of a new system.

**141.** The Committee was told that the 2023 target for the roll out may be ambitious. Cheryl Way suggested that:

"I think the 2023 target is ambitious. From my experience of working within NWIS and within a health board, you do find other projects get in the way, and there are actually papers that have been written on this. It's how many other things you're trying to do at the same time that can make it challenging. So, if, say, a health board is rolling out a new radiology or a new pathology system, there's only so much capacity that they can deal with. So, it's that sort of thing that might make it slower than we'd like it to be, because we have to take all that into account."<sup>86</sup>

**142.** The Committee raised concerns about the timetable with the Welsh Government. Dr Goodall told the Committee that he thought:

"...we can be confident about aiming for 2023. What I'd like to say is that if we achieve the successful roll-out on the first stages, we may look to revisit that timetable, but it would seem to be a reasonable experience, based on what's happened elsewhere in the UK."<sup>87</sup>

---

<sup>85</sup> RoP, 19 June 2017, Paragraph 191

<sup>86</sup> RoP, 19 June 2017, Paragraph 203

<sup>87</sup> RoP, 6 March 2017, Paragraph 38

**143.** He added that the procurement would run through 2018-19 and that this process will highlight if there are any potential difficulties with achieving the 2023 deadline.

**144.** The Committee believes that the introduction of the Electronic Prescribing and Medicines Administration (EPMA) system will remove the element of risk associated with a paper system and improve medicines management and the patient experience by reducing prescription and administration errors, and ensuring the more timely supply of medicines (including medicines for hospital discharge). However, we have a number of concerns about the length of time taken to date, and the seeming lack of accountability for not hitting key milestones. It is unacceptable that this system has been subject to so many delays to date, and as reflected in the recent Auditor General report on Informatics Systems in NHS Wales (January 2018),<sup>88</sup> this appears to be symptomatic of the issues with NHS Wales in relation to IT systems.

**Recommendation 17.** The Committee recommends that the Welsh Government shares its action plan and key milestones for the Electronic Prescribing and Medicines Administration (EPMA) system with the Committee.

### Electronic prescribing in primary care

**145.** In addition to the introduction of electronic prescribing in the secondary setting, the Committee also received a number of representations relating to electronic prescriptions in the primary care setting. During the visit to Stanwell Surgery in Penarth, Members were told that GPs spend a significant period of time, physically signing scripts, Members have also received anecdotal evidence of the delays caused by people not being able to get medication as their script was not signed, or because the paper copy had been lost.

**146.** The NHS in England has rolled out an electronic prescriptions service<sup>89</sup> over the last 10 years, which sends electronic prescriptions from GP surgeries to pharmacies, with the aim that eventually this will remove the need for most paper prescriptions. The Committee questioned the witnesses from the pharmacy sector about whether this should be introduced in Wales. Cheryl Way suggested that this might be needed going forward but that she was “not sure that a clear case has

---

<sup>88</sup> Auditor General Report, [Informatics Systems in NHS Wales](#), January 2018

<sup>89</sup> NHS Digital: [Electronic Prescription Service](#)

been made for it and anybody charged with taking it forward at this stage”.<sup>90</sup> Mark Griffiths added:

“Being a practising pharmacist, I’m not a firm advocate of electronic transferrable prescriptions. I like what we’ve got in Wales with the 2D barcoding. It makes the system work very smoothly, and I just think, as you say, there can be issues, but I think we can work these things out amongst ourselves. We don’t have to go down the route of what they’ve done in England, because it has been a tortuous route.”<sup>91</sup>

**147.** The 2D barcode is a system where a barcode is added onto prescriptions, which provides an electronic way of transferring information. However, a paper copy of the prescription is still required. This does not address the concerns of GPs who spend a significant amount of time signing prescriptions.

**148.** The Committee is concerned that there is a need to modernise the system in the primary care setting, to maximise the use of time professionals and as such full and proper consideration must be given to moving forward with introduction of electronic prescriptions within the primary care setting.

---

<sup>90</sup> RoP, 19 June 2017, Paragraph 153

<sup>91</sup> RoP, 19 June 2017, Paragraph 170



## Annex A – Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at:

<http://senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=15048>

Date	Name and Organisation
6 March 2017	Dr Andrew Goodall, Welsh Government Andrew Evans, Welsh Government Jean White, Welsh Government Alan Brace, Welsh Government
19 June 2017	Judy Henley, Community Pharmacy Wales Mark Griffiths, Community Pharmacy Wales Elen Jones, Royal Pharmaceutical Society Wales Cheryl Way, Royal Pharmaceutical Society Wales Board Member Allison Williams, Cwm Taf University Health Board Suzanne Scott-Thomas, Cwm Taf University Health Board Professor Rory Farrelly, Abertawe Bro Morgannwg University Health Board Judith Vincent, Abertawe Bro Morgannwg University Health Board Carol Shillabeer, Powys Teaching Health Board Karen Gully, Powys Teaching Health Board
16 October 2017	Dr Carwyn Jones, Furnace House Surgery, Carmarthen Dr Darren Chant, Meddygfa Teifi, Llandysul Andrew Evans, Welsh Government Professor Chris Jones, Welsh Government Dr Alun Edwards, Ty Bryn Surgery, Caerphilly Dr Alun Walters, Aneurin Bevan University Health Board Eryl Smeethe, Aneurin Bevan University Health Board

## Annex B – Record of outreach visits

### Glanrhyd Surgery, Ebbw Vale – 12 June 2017

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 a lot 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 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 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”. 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 of the patients had chronic health problems and had to take a cocktail 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 dispensed 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 with 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 cost would be to print the actual cost of each item on the prescription.

## Note from Visit to Ty Elli Surgery – Llanelli

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

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.

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”.

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.

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.

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”.

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.

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.

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.

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 deprivation and demographics within the area rather than any other factor.

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.

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.

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.

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.

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.

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

## 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 patient have drugs prescribed as on a historic prescription and don't realise that they can buy them. There is a need for consistency 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 prescribing), 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 this is 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. 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 that often there appears to be no reconciliation with the original list on discharge, and 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.