OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 4 February 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 4 February 2020

CONTENTS

HEALTH AND SPORT COMMITTEE
3rd Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jonathan Burton (Royal Pharmaceutical Society)
Gail Caldwell (NHS Greater Glasgow and Clyde)
Campbell Shimmins (Community Pharmacy Scotland)
Professor Angela Timoney (NHS Lothian)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 4 February 2020

[The Convener opened the meeting at 09:30]

Medicines (Supply and Demand)

The Convener (Lewis Macdonald): Good morning, and welcome to the third meeting in 2020 of the Health and Sport Committee. I ask everyone in the room to ensure that phones are off or on silent. Although it is acceptable to use mobile devices for social media, I ask people not to take photographs or record proceedings.

Under item 1, we will take evidence on dispensing as part of the committee's inquiry into medicines supply and demand. I welcome Professor Angela Timoney, who is the director of pharmacy at NHS Lothian; Gail Caldwell, who is the director of pharmacy at NHS Greater Glasgow and Clyde; and Campbell Shimmins, who is a community pharmacist from NHS Forth Valley and Community Pharmacy Scotland. I also welcome back Jonathan Burton, who is the chair of the Scottish pharmacy board of the Royal Pharmaceutical Society. I know that some of you have been in the room—and even on the panel—during previous discussions.

Medicines waste has been a recurring issue. I want to ask Gail Caldwell and Angela Timoney about the level and causes of waste in individual health boards and the wider lessons that can be drawn. We know from the big picture that a number of issues have been identified, including repeat prescribing and over-ordering in care homes. I ask you to start with that issue before we widen the discussion.

Gail Caldwell (NHS Greater Glasgow and Clyde): I will start by talking about waste in relation to repeat prescribing. In Scotland, there are systems that are known as managed repeats, which are often used in community pharmacy to support patients in ordering of their medicines. Normally, managed repeat systems involve the community pharmacist taking control of ordering a patient's medicines, with their consent. We have heard anecdotal evidence from health boards that such systems can lead to increased waste. However, when we looked at the data for a managed repeat service in one of the NHS Greater Glasgow and Clyde partnerships, we noticed that, when managed repeats were stopped, there was no change in the volume or cost of medicines that were dispensed in that area.

Systems for supporting patients to manage long-term conditions are really important, because we need to use the skills of community pharmacists to support people to get the most from their medicines and to check adherence and concordance with prescriptions. Such systems are also important in the management of workload and workflow in community pharmacy. The committee will have seen from CPS's submission that 100 million items are dispensed in community pharmacy each year.

Boards are supporting the roll-out of the MCR—medicines: care and review—service in serial prescribing. That does not have the same risks as managed repeats, because each time the patient presents for a prescription, the pharmacist checks that the patient requires the medicine, which reduces the number of times that a medicine is dispensed. As part of that service, in order that we support patients to get the most from their medicines, patients get a medicines review. That is important, because it means that any inappropriate polypharmacy can be assessed and changes can be made.

As I said, anecdotal evidence suggests that some systems relating to repeat prescribing generate waste. The issue is how we manage that—for example, by using systems such as MCR, which are really important strategies for boards.

Professor Angela Timoney (NHS Lothian): I will talk about some other issues. Gail Caldwell has covered what NHS Greater Glasgow and Clyde is doing to support community pharmacy, and we are also doing that in NHS Lothian. The biggest waste occurs when a medicine is prescribed that is expected to have a therapeutic benefit, but the patient does not get that benefit. There is a real issue around ensuring that patients understand and take their medicines. A medicine that is prescribed but which goes to waste is, in effect, the most expensive medicine that we could buy.

We have talked about community pharmacy, but the hospital managed service has processes to manage our waste and it has stock-control systems. Our key performance indicator is that less than 0.4 per cent of our medicines should go to waste, and we have more than met that target for the six years for which I have been the director of pharmacy in NHS Lothian.

The Convener: That is for secondary care.

Professor Timoney: Yes.

The Convener: What are Campbell Shimmins's and Jonathan Burton's takes on the wider picture around medicine wastage and unused medicines?

Campbell Shimmins (Community Pharmacy Scotland): I will speak about the ground level of community pharmacy practice. Managed repeats were a perceived problem that it has been evidenced does not actually exist. At the ground level, when a patient is reordering their medicines, we check that they actually need them. Every month or second month, we have an opportunity to question the patient and interact with them to check their understanding of why they are taking their medicines, what they are for, and whether they are having any problems. That is an on-going part of pharmacy practice, but we have brought it under one titled umbrella in the MCR service. We are going to include serial prescribing in that, because it will give us an even better opportunity to schedule workload to spend a bit more time with the patient to enquire about their adherence and concordance. We have been doing that for the past few years, but it has been formalised for the past couple of years.

At ground level, we are not seeing an increase in waste by weight, but I do not know about waste by value. We do not measure the value of the stuff that goes in the box, although there is a notional amount attached to the weight of a tablet in a disposal bin. In the past two or three years, we have probably seen fewer disposal uplifts, which is a good sign.

We also find that most adherence or concordance problems are to do with patient understanding and education. There are a lot of perceptions around certain medicines, such as anticoagulants and statins, and they can often be put to bed by giving reassurance about the frequency of side effects and what the side effects are, if there are any.

At ground level, I would say that waste is less of a problem, although it is still a problem. As Professor Timoney said, a therapeutic prescription that has not been taken is the worst form of waste of all, so there is a huge job to be done in changing that.

The Convener: If I understood Professor Timoney correctly, 0.4 per cent is the key performance indicator for hospital medicines wasted. What is your comparable figure? I know that you can do it only by weight.

Campbell Shimmins: I do not have such a KPI for community pharmacy, but there is probably someone here from primary care who could give the answer from a primary care perspective.

Jonathan Burton (Royal Pharmaceutical Society): In regard to medicine waste, I will speak to two of the key overarching principles that we picked out in our written submission.

The first is the time to care. During this inquiry, we have heard how complex medicines are and how complex people are. Those two things together mean that medicines often end up not being taken as they should be, or people end up with the wrong type of medicine. Pharmacists already impact on that problem, but if we are going to have more impact, we need the time to care—the time to have conversations. In community practice, that is about making time and ensuring that the contractual frameworks support having the time to speak to people when they are ordering their medicines, whether those are opportunistic interventions or planned interventions.

Our pharmacist colleagues who work in general practices also need time to care for their patients, and it is not only about managing the churn of repeat prescribing. That is a significant workload, but they also need the time to make interventions and have really good conversations with patients to get to know them better and build trust; that is when they can really start to make an impact.

The second key point, which we have gone back to time and again, is about information technology connectivity. It is one thing for me to spot an issue in practice, but communications-wise, I am effectively isolated from the rest of the system. When I spot something that is not quite right, or if I address an issue, I want to be able to share it with my general practitioner pharmacist and GP nurse colleague quickly and effectively, because I might need their assistance in getting a solution over the line. We are talking about read-write access to records and the importance of sharing the good work that we do in community pharmacy with our colleagues in GP practices, and making sure that they can communicate back to us with no barriers.

The Convener: We have heard a bit about managing repeat prescriptions. When a prescription is delivered to a patient's home, is that repeat prescription managed? If so, by whom?

Jonathan Burton: The RPS has a professional guidance document on what are loosely termed managed repeats, which come in several shapes and forms. A classic example would be a patient who, for whatever reason, currently has their medication in some form of monitored dosage system—a medicines tray is another term for that. That brings with it a lot of technicalities to do with the time that goes into preparing that. Pharmacies tend to micromanage it to a certain extent to make sure that prescriptions are processed in time and that the technical task of getting the tray put together is done in a timely manner.

When patients get medicines delivered, that can sometimes be quite tightly controlled by the GP practice and the pharmacy; at other times, the patient will have a delivery for other reasons and they might have quite a lot of control over their ordering. However, our professional guidelines

state that the patient must be involved in those processes in one way or another, depending on what the particular situation is. It is important not to lose sight of that because if we are not having those conversations with the patients, they could end up on medicines that they do not need or do not want.

Gail Caldwell: Another scenario in which patients might have medicines delivered to their home is via what is called a homecare system. If a patient attends an out-patient clinic, the prescribing and monitoring of their medicine can be done through that clinic but it will be supplied to the patient through a homecare arrangement, saving the patient from having to come back to the hospital. Normally, that happens when it is a long-term condition, and that condition is still being managed through the hospital outpatient clinic.

In the past few years, NHS Scotland has done quite a lot of work to recognise the importance of the governance frameworks for medicines that are delivered through the homecare system. Sometimes, when manufacturers make their medicines available to us, they make the homecare route the preferred route of supply for that particular medicine.

Sandra White (Glasgow Kelvin) (SNP): With regard to patients who are not able to come to the pharmacy, you mentioned the homecare system, use of technology and so on.

You have a chat with the patient if they go to pick up their prescription but do you have a chat with a relative or anyone else who might pick up the prescription for them? I feel that that is a blockage because that person will just pick up a repeat prescription and take it back home for the patient. Do you phone the patient or do you take cognisance of the fact that a patient has not been seen in the pharmacy for a couple of months and someone else is picking up the prescription, so you do not know if the medicine is still suitable?

Campbell Shimmins: The beauty of community pharmacy is that we are at the heart of a community; we know our patients. We see the same people regularly—they see the same pharmacist, more often than not, or the same pharmacy team. It is apparent when patients transition from wellness to illness and become more housebound and more dependent on friends, neighbours and family members. We react to that and offer various supportive aids around ordering, delivery and management of their medicines to accommodate that.

If the change is sudden, our pharmacies would certainly contact the patient, but we would also ask the person who is collecting the prescription what their relationship is to the patient and how the patient was. The committee can rest assured that one of the first things that we notice is somebody else collecting a patient's medicines for them. We would contact the patient and explore with them what the best solution might be, bearing in mind their condition, which might be long term, acute, or transient.

09:45

Sandra White: If the medicine does not change, and someone comes along once a fortnight or whatever to pick it up for the patient, there is no way of knowing whether the patient is using it. I think that that is quite a common scenario. Given that we are talking about medicines waste, how do we manage that situation?

Campbell Shimmins: That is a problem, but it is as common as you might think. Patients—in Scotland anyway—treat their medicines with a degree of respect. We have to give patients some responsibility for management of their medicines, and we support that responsibility. That is what we are about.

We do not call the conversations that we have with patients "consultations", because we are talking about the people in our community, and it is usually quite easy to identify from what they say, from their returns, and from visiting their homes, what medicines they are using. If they are using a monitored dosage system, it is apparent if they are not using their medicines because they are returned to us unused.

Sandra White: Is it a normal occurrence for a pharmacist to visit a patient at home?

Campbell Shimmins: No, that is not normal.

Sandra White: No. I have never heard of that happening before.

Campbell Shimmins: There is no formal process for doing that. However, when we identify an unknown risk to do with medicines—medicines can be dangerous—we take it upon ourselves to double-check that the medicines are getting to the patient, that the patient is doing all right, and that the medicines are being used appropriately.

I am sure that we could build a service including home visits. With the advent of pharmacotherapy and practice-based pharmacists identifying patients whop have greater needs, we are moving towards that, but it is probably still a long way off. In addition, it would probably need greater social care involvement, so the integration of health and social care will be important in developing such services.

David Torrance (Kirkcaldy) (SNP): Some of the submissions to the committee have highlighted instances in which the usual risks of recycling unused and uncollected medicines might not

apply, such as unused medicines in care homes and medicines not collected from a community pharmacy. Could, or should, medicines that are not collected from a pharmacy or not used in a care home be reused? If a medicine is not collected from a pharmacy, is the pharmacy still reimbursed by the NHS?

Gail Caldwell: I will start. I am sure that Campbell Shimmins and Jonathan Burton will also want to come in.

My professional standards as a pharmacist tell me that I cannot guarantee the quality of a medicine that has left the supply chain. If it has gone out to a care home or a patient's home, I cannot be sure how that medicine has been stored. To resupply or redispense it to another patient without being sure of the quality would cause me concern.

We reuse medicines in the hospital service. One of the challenges in hospitals is that patients move quickly around the system. In those circumstances, we recycle the medicines around the hospital system because they have not left the supply chain and I can be confident about how they have been stored and looked after during that process.

The Convener: Once a medicine has left the building, in your view, it is not useable.

Gail Caldwell: I cannot guarantee its quality.

Jonathan Burton: On reuse of medicines, once something has left the building, we do not have control over the parameters that enable us to guarantee that that pharmaceutical product is what it says on the tin. Again, our professional standards in pharmacy have always guided us to follow the principle that, once we lose visibility over how that item is looked after or stored, it is generally deemed inappropriate to reuse it. In recent years, there has been challenge to that approach. There is also an environmental aspect. However, as yet, none of that has managed to permeate into our core professional guidelines.

I turn to some of the trickier aspects of David Torrance's question. In mentioning the use of medicines in care homes, the RPS submission refers to a situation in which items such as nutritional drinks are needed by, say, a fifth of the patients in a particular care home. We have suggested that care homes should be able, in effect, to bulk order such items and draw them down as required. That would help us to avoid a situation in which 20 cartons of a drink are prescribed for an individual patient but the recommendation is then changed and we cannot reuse the item. Simple common-sense things such as that could be done, particularly for nutritional and surgical items. There might be some easy wins there.

The most complex or technical thing that David Torrance asked about—and the most difficult thing to give an answer on—is reimbursement for uncollected medicines. Part of the reason for the difficulty is to do with the electronic payment systems that we have in community pharmacy. I am sure that my CPS colleague will be able to elaborate, but it is fair to say that our systems are not technically proficient enough to account for every last tablet in the system that might or might not be collected by a patient.

A certain amount of professional judgment and discretion and a sense of fair play are required in the pharmacy in relation to what is submitted for reimbursement and what is not. For example, we might dispense to a patient 95 tablets out of 100 because we do not have the other five in stock. If the patient never collects the other five and they just sit on our shelves, there is currently no way, technically, to ensure that we are paid for only 95 and not 100.

The flipside is that we are expected to maintain a significant inventory of medicines in order to ensure that we can supply things promptly, but within the system there is no reimbursement to contractors for medicines that, for example, go out of date, are inadvertently damaged or otherwise cannot be used.

There are some technicalities around the issue, but I suppose the answer is that pharmacists should abide by professional standards when choosing what they are and are not reimbursed for. There is a general principle that we are reimbursed for what we dispense and not for what we do not dispense, but our systems are not technically proficient enough to land that on the nail, as it were.

Campbell Shimmins: The systems are not wonderful. They are good—they are getting there—but they are not perfect.

On dispensing a prescription, we have a 14-day window in which we can claim for it. Normally, the patient has two weeks in which to come and collect the script before we have to scan it in order to claim for it, so we have that buffer. That captures most of the uncollected stuff because, if a script is not collected, it is scanned as "not dispensed". That is the guideline. A lot of the uncollected stuff for which we would otherwise not be reimbursed is submitted as "not dispensed". Often, we will contact the patient and say, "Did you know that this is sitting here waiting for you?" However, given the way that the system works, it is rare to have things sitting for more than 14 days, other than balances, which Jonathan Burton mentioned.

The Convener: How often are medicines not dispensed? In such cases, what happens to the medicines that are physically sitting on your shelf?

Campbell Shimmins: I cannot give you a full statistical answer. For medicines that are sitting in a pharmacy, I know that it will be less than 2 to 3 per cent. It will probably be a lot less than that, actually—I am being generous. If a medicine is sitting in a pharmacy and it has been stored properly, it will go back on to the shelf. If the pharmacy has not been reimbursed for it, it will still be owned by the pharmacy, if you like.

The Convener: Jonathan Burton gave the example of only 95 tablets being collected out of 100. How often do such things happen? Is that a frequent occurrence?

Jonathan Burton: It happens increasingly infrequently because we have moved towards a situation where, the majority of the time, we use what we call patient packs. Except for things such as antibiotics, for which there are lots of different courses and arrangements, the majority of patients get original pack dispensing. That is supported even more now that we have adopted the falsified medicines directive with scanning technology that is designed to ensure that products in our supply chain are genuine and not counterfeit. That reinforces the importance of original pack dispensing.

As technology moves on, we get better at keeping in continuous touch with patients about their medicines. Most of us have text-messaging ability. A lot of that is facilitated through NHSmail, in the same way that people get an NHS text when they have a dental or an optical appointment coming up. Pharmacies can and do use that technology to remind patients that their medicines are waiting to be collected. That can be extremely handy at bank holidays, for example, when it is important to let people know that we have their medicines ready for them. A lot of patients sign up for that service.

Miles Briggs (Lothian) (Con): Good morning. I want to pursue the issue of communication between pharmacists and prescribers. Medicine reviews have been mentioned. If you do not think that what someone has been prescribed is appropriate, or if they do not want to take a medicine, how do you feed that back to a GP? If you try to supersede a GP on their decision on a prescription, does that result in conflict?

Campbell Shimmins: In practice, we do not have conflict. First, it is a question of reaching consensus with the patient. If the patient expresses doubts or concerns about a medicine and we cannot allay them using all professional knowledge and skills, the prescriber has a responsibility to reach a consensus with the patient on what they can have to best treat their condition.

A community pharmacist is not piggy in the middle; they are part of a triumvirate and will feed it back to the GP that patient X is not taking a medicine for such-and-such reason. Whether the pharmacist thinks that he or she should have that medicine does not form part of the conversation. If the GP seeks our advice, we can offer it, and sometimes we do, depending on the relationship. However, as far as I am concerned, it is for the GP to go back to the patient and reach a consensus with them.

Occasionally, a GP will phone up to ask what we would recommend in the circumstances, in which case we will offer a recommendation, but conflict is extremely rare.

Gail Caldwell: Through implementation of the new general medical services contract, an increasing number of pharmacists and pharmacy technicians are working within general practices to support what is called the pharmacotherapy service. In my board, we are seeing much better partnership working between the pharmacy teams in the practices and the community pharmacists. That means that, when such issues arise, a conversation can be had that, as Campbell Shimmins said, puts the patient at the centre of the process to ensure that the best outcome is achieved for them.

Professor Timoney: I would like to pick up on what Gail Caldwell said. In NHS Lothian and in most boards across Scotland, we have really good working relationships between pharmacists and general practitioners. We have long-standing experience of working with our GP colleagues and speaking to them about new formulary recommendations—we might say, for example, “The formulary has changed, so you might want to think about changing your patients’ medication”—new clinical guidelines that have been put in place and new evidence about adverse effects of medicines. I think that GPs expect us to have such conversations with them, and they tend to be had in a very educational and supportive professional environment. That is a strength of the primary care system.

10:00

Miles Briggs: Do you record such data? We know all about the issues with poor IT and access to patient records. If you do not dispense something for which somebody has come to you with a prescription from their GP, do you record the fact that that has been reviewed?

Jonathan Burton: The honest answer is that it is down to the pharmacist’s professional discretion and judgment whether to keep records of such

events. You raise a good point—it is very difficult for us to collect data in this area. That is a personal frustration of mine. It means that a lot of the good work that is done in community pharmacy practice is, in effect, completely invisible. There will always be local variation, but relationships between community pharmacies and general practices are usually good.

From time to time, there are frustrations that might be to do with the inability of professionals to speak directly with one another, which is a symptom of the fact that we are not properly plugged into the system. Every time I spot a discrepancy on a prescription, I need to make a judgment call. It might be a technical issue that simply requires me to send the prescription back with a note—yes, we are still in the world of Post-it notes, which is shameful—or I might need to pick up the phone and speak directly to a clinical colleague, if there is a clinical aspect to the case that is individual to the prescription. However, it could be a more general issue, such as a medicine-supply issue. I might need to flag with a GP that we are having a supply issue with a medicine or group of medicines and ask them to have a think about their preferred choices for that patient group, so that we do not keep hitting up against that issue time and time again.

However, some good conversations are taking place. I will give an example, although I will anonymise it and change some of the details. About five or six days ago, I received a prescription for antibiotics. The patient had a slightly atypical skin condition and the antibiotic dose on the prescription was really high—higher than I had seen before. I felt that that was worth a telephone query, because I really wanted to get to the bottom of the issue. Was it a genuine prescribing error or something so specialist that I did not have visibility of it, such as a consultant recommendation? I do not see patients' notes—even with their consent—so I was flying blind and needed to phone the GP.

We had to start right from the beginning: I had to tell the GP why I was phoning and they had to tell me what they had done to get to that point. We eventually reached a consensus that the dose was a little bit high and that we needed to manage it down. I explained to the GP that I had gone to my usual references, that I knew a little bit about the condition and that I had not come across such a prescription before. We had a really good professional-to-professional conversation about it, which was a bridge builder. The GP is a locum and we will probably have more conversations in the future, because there is a bit of trust there now through having spoken to one another in a polite and professional manner, and working on the problem and solving it.

Such conversations happen all the time, but they are invisible and they are made more difficult by the fact that we are fenced out of the IT system, which is frustrating for our GP colleagues. It is also frustrating for our general practice pharmacist colleagues, with whom I would like to have better communication. I agree with the previous speaker on their point that colleagues in our community pharmacy and general practice pharmacy teams—be they pharmacists or technicians—are starting to have many such conversations. When it is purely a technical medicine issue, we can work out the problem together with no issue at all and, as long as there is a bit of trust and respect on each side, that is a really good thing. However, communication could be made easier for us.

Miles Briggs: In your day-to-day professional life, what percentage of prescriptions is it appropriate to query? You can just give me a guesstimate.

Jonathan Burton: Studies have been done. This statistic is completely off the top of my head—either back me up or shoot me down here, colleagues—but I think that around 5 per cent of prescriptions are technically not quite right. That encompasses a wide range of issues—from prescriptions that are clinically inappropriate to purely technical issues that are not patient-safety issues. There have been some fairly large studies on rates of errors in prescribing. Other panel members might be able to elaborate on that.

The Convener: If you are able to track down that information after the meeting, it might be helpful.

Jonathan Burton: We can get back to you on that.

The Convener: Does the Royal Pharmaceutical Society have a role in collecting such data?

Jonathan Burton: Yes, we will be able to pull out that information. There have been some reasonably decent-sized studies on prescribing safety and the rates of prescription errors. However, as I said, what such studies class as errors are perhaps not what we would class as true medical errors, because they include clerical errors such as small typos.

Gail Caldwell: It would be helpful for the committee to see some of that work.

Let me build on Jonathan Burton's point about the importance of community pharmacists having access to records. In NHS Greater Glasgow and Clyde, 63 per cent of our community pharmacy contractors now have access to the clinical portal, which is the electronic patient record. We are gathering evidence of cases in which harm has been prevented by the community pharmacist having access to those records.

In a very recent example, a patient had attended an out-patient clinic, where a recommendation was made to the GP, who prescribed a medicine. When the patient presented the prescription to the community pharmacist, the pharmacist started a conversation with the patient and thought that something was not quite right about her understanding of the medicine. With the patient's consent, the pharmacist was able to access clinical portal and look at the out-patient letter. They then discovered that the wrong medicine had been prescribed.

That relates to Jonathan Burton's point about errors. If that pharmacist had not had access to the information, the error might not have been detected. Access to information for our community pharmacists, to support safer dispensing, is really important.

The Convener: I think that committee members will be encouraged to hear about that. What has been the process to reach a position whereby 63 per cent of community pharmacists have access? What is required if you are to reach 100 per cent?

Gail Caldwell: It has been about work in the board on information governance issues, as well as discussions with our Caldicott guardian, to establish the appropriate role-based access. It would not be appropriate for community pharmacists to see the whole clinical record, but there are key parts of the record, such as out-patient letters and information about drugs and medicines that are given to the patient on discharge, that it is important to be able to see. As well as considering the information governance issues, we have worked through role-based access arrangements, agreeing the fields that it is appropriate for community pharmacists to see.

After that, it is down to the technical aspects. That is why we are at 63 per cent. We have technical challenges with some of our community pharmacists, which we are working through. We have made progress quickly since the end of last year; it is just a question of working through the technical aspects to do with how we share information with the wide range of community pharmacists.

Brian Whittle (South Scotland) (Con): You mentioned the new GMS contract. The committee has heard evidence that the increased role of pharmacy in general practice is leading to a workforce issue that relates not just to pharmacists but to pharmacy technicians. In some submissions to the committee, people have called for the pharmacy technician role to be expanded.

Jonathan Burton talked about the need to create the time for pharmacists to do the job that they are trained to do and to ensure that they make best use of their skills and training. Will the panel talk about the potential to expand the role of pharmacy technicians—for example, to allow them to dispense medicines?

Professor Timoney: You have raised an important issue. The new pharmacotherapy service has built on lots of experience over 20 years of pharmacists in Scotland working in general practices with their GP colleagues. The pharmacotherapy service was partly a GMS-contract response to the challenges that GPs are having in meeting patient needs, given changing demographics.

The service is evolving. We are moving on from having pharmacists doing some of the tasks to having technicians do them. We need to move further than that and involve support workers and admin and clerical staff. We need to get clarity on who can best perform each role.

In NHS Lothian, to address the skills gap, we have just created a workforce: we have funded 30 people to become pharmacy technicians, through Edinburgh College. We are trying to build a workforce and maximise the use of the pharmacy technician professionals by having them work to the top of their licence. We are moving strongly in that direction.

There are lots of pressures in the system. There are pressures relating to the number of staff on community pharmacy and on my hospital service, but workforce is an issue across the NHS. Rather than taking staff from one part of the service and using them somewhere else, many people are trying to develop new staff and capacity in the system.

I do not know whether that addresses Mr Whittle's question. In effect, we are using technicians in our general practices to the top of their licence so that they can do as much as possible. Pharmacists allocate pieces of work to them, which allows the pharmacists to have oversight of that and to work on the more complex queries and issues with patients.

Brian Whittle: I have heard evidence from a well-known high street chain—it was not the only time that I have heard this—that developed its pharmacy technicians to dispense medication and perform other tasks only for the NHS to plunder those technicians and take away that workforce. The incentive for pharmacies to develop their pharmacy technicians is obviously an issue. Are you aware of that? If so, will you comment on it?

Gail Caldwell: You raise a good point. You described the way in which we are developing the pharmacy technician profession to work at the top of their licence, as Angela Timoney said. Many pharmacy technicians train as what we call accuracy-checking technicians. Their skills are developed to allow them to check prescriptions

that have been clinically screened by a pharmacist.

You are right that those accuracy-checking technicians are often trained in the community pharmacy environment and then sometimes come to work in our hospital pharmacies. Campbell Shimmins and Jonathan Burton might want to comment on that. We get quite a bit of movement of staff. Therefore, it is important that we have a pipeline for our pharmacy technician workforce, so that we can grow that workforce in and for primary care. Angela Timoney described the work that NHS Lothian is doing, which is setting the precedent on that. There are anecdotal reports of pharmacy technicians being trained in community pharmacy and not being retained there but moving into other environments, such as the hospital pharmacy service.

Jonathan Burton: As with most workforce issues, this one is complex and has lots of different levels. In part, the issue is about pay and conditions and human resources matters. In our written submission, the RPS put a lot of focus on career pathways for pharmacy technicians, which I would expand to career pathways for pharmacy support staff in general. A lot of work needs to be done on the issue. Across the various services that we offer, we need an appreciation that we must get our workforce planning right.

10:15

Pharmacists and pharmacy tech skills and knowledge are in demand across primary and secondary care, so we need a pipeline, but we also need to think about what those individuals are doing in practice. From a community pharmacy practice point of view, the contract is evolving and developing, and we are just about to launch the next phase of our Pharmacy First patient facing walk-in services. Those changes are fundamentally changing the demands on pharmacy teams.

There is still the technical demand for the accurate and safe supply of medicine, but pharmacists in community practice now also need people who are good clerically and in a reception sense—they need people who can manage consultation workflow as well as prescription workflow. There are great opportunities there, especially for our technician workforce. We should not think of our technicians only as an additional help in the dispensing process, although that aspect is vital; we should think about how our workforce can handle our increasing consultation-based workload, and we can create some attractive careers there.

On the pipeline, we need to recognise that the NHS really likes its pharmacists and techs and that we need some assistance with promoting pharmacy as a career right from school level. Traditionally, we are very back office, but that is changing rapidly, and there are a lot of young people in Scotland who have a lot to offer our profession. We really need to shine a light on that, and, as a profession, we would ask the Scottish Government for as much assistance as it can give us.

Sandra White: I will move on from pharmacies in the community to pharmacies in hospitals. We have heard evidence of unnecessary pharmacy delays and of people waiting for prescriptions, which can have a knock-on effect on the discharge of patients. What are the causes of pharmacy delays in hospitals and what can be done to address them?

Gail Caldwell: When we supply medicines to a patient on discharge, we first need an accurate prescription from the prescriber. The delays that are placed in the pharmacy are often because we do not have a prescription. On the ward round, you could be told at 9 o'clock in the morning, "You can go home today," but sometimes it can be well into the afternoon before the junior doctor gets round to writing the prescription. Meanwhile, the patient is sitting, potentially in a discharge lounge, waiting for the medicines, but we in pharmacy do not have a prescription. The process is quite complex.

When we are supplying medicines for patient discharge, we also have to make sure that they are right. We know that the transitions of care, when patients move from acute care to primary care, are risky in terms of communication, so we have to undertake what we call medicines reconciliation at that stage. We have to make sure that the medicines are right.

Therefore, we have often got delays in the availability of the prescription and we also have to make sure that it is accurate.

From data in Greater Glasgow and Clyde, we know that it takes us about three hours from when we receive a prescription to get the medicine ready. We know that, in our hospitals, we have significant challenges with capacity and flow. For a patient to wait even three hours for a medicine when they have been told that they can go home does not feel very person centred.

We have recently submitted a bid to look at a new model for discharge supply, which builds on examples from systems in other countries around the world, such as New Zealand. If a patient is going home from hospital, we could transfer the electronic prescription—the electronic immediate discharge letter—to the community pharmacist, who could pick up the supply. When the patient is on their way home, somebody could pop in and

collect that medicine. Again, it comes back to the need for access to information.

We need to keep the systems that we have under review; we need to make sure that they are person centred. I agree that the hospital discharge process is not as person centred as I would like it to be. Some of the new ways of working, including the transfer of information to the community pharmacist, who picks up the supply, perhaps delivers the medicine to the patient's home, or has someone collect it, and supports the information sharing with the practice about what has happened during the hospital discharge, are the way to go to improve the systems that currently impact on patients going home.

Sandra White: Thank you. I have waited five hours on occasions. Sometimes the pharmacy is closed, so you are not allowed out and have to stay in hospital overnight. It seems a crazy system.

Gail Caldwell said that the consultant has to prescribe. They are very busy, so there is a blockage there, which creates a waiting time for people. There is also a lack of electronic prescribing methods. Would HEPMA be helpful and would it alleviate the delays? Professor Timoney, I notice that the NHS Lothian submission says:

> "It is important that the Scottish Government's funding commitment to HEPMA (Hospital Electronic Prescribing and Medicines Administration) is honoured."

Can you or others on the panel elaborate on that? If we introduce HEPMA, will that alleviate the daily pressure on hospitals that means that people are sometimes waiting four or five hours?

Professor Timoney: You have asked a couple of questions there and I will come to HEPMA second. One of the things that you should recognise is that not every patient in hospital will have seen a pharmacist. We are a short resource, so we have to assess risk and prioritise those who we think are on risky medicines or have conditions that cause us to be concerned about medicines and medicines use. As a result, by the time the prescription comes to pharmacy, it may not have had that clinical check. That is inevitable given the pace of what is happening in hospitals at present. Patients come in and go out quite quickly. It is the junior doctors, rather than the consultants who are writing the prescriptions and, to be fair to them, the juniors know that there is someone coming into that bed and that they have to get them clerked in, too.

At the moment, everything in the system is running quite hot. We recognise that it is not perfect. Sometimes when things run hot, we get clogs in the system that should not be there. That is the current situation.

It is essential that we get HEPMA in place across all hospitals in the NHS in Scotland. We have good systems in primary care; we have seen the quality of prescribing in primary care improve dramatically in the past 20 years as we have had more data to review what is happening, to make recommendations about practice and to feed back to prescribers. That is what we will be doing with the HEPMA system.

First, we will be able to see whether prescribing is in line with our formulary and the clinical recommendations. We will be able to see the medicines administration and whether patients have got their medicines. We will be using that process to improve the quality of care for patients. I hope that some of that will result in patients having their medicines available when they are being discharged because the system is working more efficiently. However, it is not specifically designed around discharge; it is designed to improve the quality of care for patients in our hospital service. That is a critical issue.

We have talked about this a little bit, but one of the strong messages that I would like the committee to get is that we need to be living in the modern world and using big data to drive improvements in care. One of the challenges is that we do not yet have a particularly strong system in the hospital service, but even in community pharmacy gaining the ability to move across interfaces and use that data to drive improvements in care would be a critical change and a real improvement in patient care.

Gail Caldwell: I want to give the committee a sense of the scale of prescribing in hospitals. Across NHS Greater Glasgow and Clyde, we prescribe 5 million in-patient prescriptions, which generate 24 million medicines-administration episodes. At the moment, those are all handled on paper—we use paper prescriptions. As Angela Timoney says, that provides us with no decision support, so there is no point-of-prescribing support for the individual about drug interactions and so on. It also means that there is a lot of handwriting in our hospitals.

As Angela Timoney says, the introduction of HEPMA, as well the patient safety data, will reduce the amount of transcription that is required, which will improve the efficiency of the system. If we can link information on prescribing with patient outcomes, we will get a sense of the true value of medicines in the system, as Angela Timoney said earlier. By having that data, we will understand not just the cost but whether we are getting the patient outcomes that we are trying to achieve with the medicines.

The Convener: Many wards these days seem to operate by having physician associates or nurse practitioners make many of the clinical decisions.

What difference would it make if those professions could prescribe?

Professor Timoney: At the moment, we have lots of nurse prescribers in our systems, as well as pharmacy prescribers and prescribing radiographers and physiotherapists. At the moment, physician assistants and associates are not a regulated profession, so they are unable to prescribe. However, I understand that that is expected to change later in the year. That is helpful, because they are working closely with patients. However, it will also add complexity to the system, which is why we need technical and data-driven solutions so that they work for all prescribers and not just for individual groups.

Gail Caldwell: Over the past few months, NHS National Services Scotland has held three discovery workshops to look at how our current systems for prescribing and dispensing will work in a multidisciplinary context. We expect the report from that work quite soon, and I think that issues such as true electronic prescribing in primary care as well as in secondary care will come through strongly in that. The committee might therefore want to have a look at that discovery report when it is published by NSS.

Brian Whittle: HEPMA's role is in the secondary care environment. What is your sense of how the data that is collected by HEPMA will be transposed into primary care for patient-centred care? Surely that patient data will be required by primary care and community pharmacy once the patient leaves hospital.

Professor Timoney: Absolutely—that is the next step. Once we get HEPMA in place in the hospital service, the issue is the connectivity across the interfaces. At the moment, that does not exist. It is probably quite shocking for patients to realise just how little we know about the medicines that they have in hospital. A lot of it depends on having medicines governance systems in place, with formularies across primary and secondary care so that we can look at compliance. We hope that our prescribers, as part of their continuing professional development and attention to detail, will share that information so that we can see what is happening. At the moment, those systems are not there, but they have to be.

Gail Caldwell: NHS Ayrshire and Arran has the most mature implementation of HEPMA in NHS Scotland and it has recently started to extract data from HEPMA when the patient is discharged from hospital and share that with primary care. That shows not only the medicines that the patient has on discharge but the journey of those medicines during the patient's stay; it shows what has been started, what has been stopped and the reasons for that. As Brian Whittle indicated, that provides rich information for primary care colleagues and, ideally, community pharmacy colleagues to get a sense of the changes that have been made and the reasons why.

Jonathan Burton: I want to come back to the topic of the perception of medicine supply in hospitals and the particular frustrations about discharge issues. I want to speak to the human element of our pharmacists working in hospitals in Scotland. A sizeable number of hospital pharmacists are members of the RPS and they have been speaking to us about how they feel about things. We have a lot of pharmacists—some of our more junior hospital pharmacists—going through the initial stages of their post-registration training and working incredibly hard to make sure that patients and their medicines are stewarded safely on both admission into hospital and, importantly, discharge from hospital. It is not an understatement to say that where we are at with our systems does not do justice to the hard work that they put into keeping our population safe.

At the RPS, we are in the process of doing a big piece of work on mental health in the pharmacist workforce and we have some of the provisional findings of a big survey that we conducted towards the end of last year. It makes quite difficult reading, and the issues to do with stress in the workplace are not confined to any one sector of our profession. That is a symptom of the fact that our services are in great demand, which is good and positive, but we have a lot of pharmacists and technicians in our workforce working incredibly hard to keep the show on the road. I know that our profession is not unique in that regard, but that needs to be acknowledged. Once our systems come along and we become more connected, that will, I hope, display a bit more openly the good work that is being done.

As our pharmacists become increasingly committed to the admission and discharge process, we need to remember that that could lead to them spending less of their time on the wards. Traditionally, pharmacists' expertise supports our medical colleagues to make good and prompt decisions that lead to smoother discharge. It is a resource issue; medicines are complex and a massive expense in our health service. They are fraught with risk, so our pharmacists need to be all over the process at all stages. Ultimately, that will lead to a better experience for patients.

10:30

I agree with and support the move to investigate the possibility of more out-patient discharge-type dispensing through community pharmacies. That would be a positive way to keep our relationships going with our patients. When they are in hospital,

quite often they become invisible, although we have made great inroads in that regard. In NHS Ayrshire and Arran and NHS Forth Valley, we have full visibility electronically of discharge notes; we know when our patients have gone into hospital but we do not know why. The movement is in the right direction. I pay tribute to our pharmacists in our hospitals, who work incredibly hard to keep patients safe when they are at their most vulnerable and poorly.

Emma Harper (South Scotland) (SNP): I hope that my question will not open up a can of worms. Are blister packs part of HEPMA or community pharmacy recording? They are supposed to improve efficiency and maybe reduce waste and support safety. However, there is the manual component of assembling the packs, which obviously takes time. Do we record electronically who is on a blister pack and who needs to be on one? There are pros and cons either way.

Gail Caldwell: As you say, it might be a can of worms. I will start with the communication between our hospital and community pharmacy colleagues. Patients who are on compliance aids, or blister packs, are often in a high-risk patient group, so it is very important that our community pharmacy colleagues know when such patients are admitted to hospital and when they go home, so that they have adequate information and time to pick up the continuity of supply.

Blister packs and compliance aids are sometimes viewed as a panacea, but I do not think that that is so. They are a solution to supporting patients to take their medicines as intended, but they bring risks. Some medicines in a compliance aid are not stable, and they can disempower the patient. Sometimes it would be better if the patient had a polypharmacy review to explore other strategies such as medicines administration records, known as MAR charts, or large-labels technology that could support better compliance. We ought to communicate better about that important area of risk, but I am not sure that compliance aids are necessarily a panacea.

Campbell Shimmins: I will give a community perspective on what Gail Caldwell has said about compliance aids. I reiterate that they are not a panacea. They have a place and can be very useful at a specific time in a patient's lifetime or journey, but they increase rather than decrease risks. As Gail said, other strategies are better choices. It is probably more cost effective and clinically effective to support a patient by prompting, de-prescribing, carrying out polypharmacy reviews or reducing the complexity of dosage regimes, for example, from five times a day to twice a day or even just night-time dosing. The issue is much more complex and the solution is not always just to stick someone on a compliance device.

From our perspective, the workload that is attached to compliance aids is enormous. It is colossal. We have to assess the risks, and the more we have, the more complex it becomes and the more people we have to employ. Dispensing an MTS pack remunerates us in exactly the same way as dispensing a serial prescription under a care package. There is no driver from us to do them.

The Convener: Thank you. That is very helpful.

David Torrance: Community pharmacies spend time trying to procure medicines, and many hospital medicines are procured centrally by NHS National Procurement. How well does the central procurement model deal with medicine shortages?

Professor Timoney: When the committee asked that question in a previous meeting, Lindsay McClure from NHS National Procurement responded. We work closely with Lindsay on procuring medicines for our services. NHS National Procurement has shifted its approach a little so that, rather than procuring purely on the basis of price and cost, it procures on the basis of having consistency of service and a fall-back to ensure that, if a supplier cannot supply because there is a shortage, the supply can come from somewhere else. That has helped us.

However, medicine shortages are currently a big problem that affects community pharmacy and hospital pharmacy. We normally run at a rate of about 80 shortages at a time; we are probably running with 120 or 130 shortages at the moment. We spend a lot of our time ensuring that we have the medicines that we need, and we grade medicines according to the risk that is associated with them. We have shortages in some really important medicines, including chemotherapy medicines, which mean that we have to make decisions about patients' treatments—we have to consider whether we have enough to last for a course of treatment for a new patient. That is part of what we do on a regular basis.

NHS National Procurement does a great job, but medicines supply is a just-in-time process and, if no medicine is available and it cannot get a supply, we all struggle.

Jonathan Burton: I defer to Lindsay McClure's comments on central procurement; she is the expert. She highlighted that, for very particular examples, such as flu vaccinations, there can be benefits but, when it comes to the wider scope of medicines that we supply through secondary and primary care, which is absolutely huge, our current system is pretty robust.

Patients in Scotland receive their medicines through a network of about 1,250 community pharmacies and an additional number of dispensing doctor practices. We need to remember and value how robust and locally versatile that medicines supply service is. When the chips are down—for example, when we have 3 feet of snow—we get our skis on and get the medicines to people in communities. It gets done, and that is incredibly important, especially when we are dealing with remote and rural communities.

Our supply chain is very spidery; it is more complex than it has ever been. We have some frustrations with direct supply models, whereby companies in effect trade their medicines directly to us rather than through a wholesaler, which means more phone calls, more emails, more websites to visit and more methods of communication. However, our having wholesalers who supply a myriad of different medications and our having pharmacies all over the country means that the system is fairly bullet-proof and we have a bit of a cushion when things go wrong.

That said, there is no doubt that medicines supply issues in primary care are taking up a lot of pharmacy staff time. They are taking up a lot of pharmacists' and GPs' time, and they are certainly taking up a lot of general practice pharmacists' time, because a lot of the communication that we do around shortages is with our general practice pharmacist colleagues.

Community Pharmacy Scotland has excellent guidance in that regard. In Scotland, we interpret the medicines supply guidance in such a way as to give practitioners a lot more flexibility in how to deal with supply problems than our colleagues in the other devolved nations have. That is worthy of note.

There is no doubt that medicines supply is resource intensive and frustrating, because every minute that we spend trying to source an awkward medicine is a minute that we are not spending with a patient.

George Adam (Paisley) (SNP): Over the past couple of weeks, the committee has heard that branded drugs cost a lot more than generics and that, even though generic drugs are the most-dispensed drugs, on the whole the branded ones are the ones that cost. Community Pharmacy Scotland has asked for pharmacists to have the power to substitute generics for branded drugs. We would have to change the legislation to allow pharmacists to do that, but the suggestion makes sense to me. Do panel members support that call from Community Pharmacy Scotland? If not, why not?

Gail Caldwell: I would always encourage generic prescribing and the supply of generic medicines where that is clinically appropriate. However, there are some situations in which we cannot use generic medicines. For example, it is important that medicines for epilepsy, theophylline-type medicines and calcium channel blockers are prescribed specifically for individual patients, and we cannot substitute brands in such cases. Although I support generic prescribing and dispensing and we do that in our boards—our generic prescribing rates can be up to 80 or 90 per cent—it is important that we maintain supplies of branded medicines for a small percentage of patients.

Sometimes it is about preference. I am not necessarily suggesting that the approach is based on patient preference, although that can also be important if it leads to good compliance, but for certain conditions it is clinically important that we use branded medicines, where appropriate.

Professor Timoney: The first thing to recognise is that the manufacturer of a branded medicine will have a patent, which will usually be for 10 to 12 years by the time the medicine comes to market. The manufacturer will have exclusivity, which rewards them in recognition of their research and development costs, and a generic will not be available until the branded medicine patent expires. At that point, as Gail Caldwell said, we would support all patients getting a generic medicine except in the case of narrow therapeutic index drugs, where there are clear reasons why we must stay with the brand. We work closely to make sure that that happens, and I would support substitution if necessary.

We have high generic prescribing rates of about 85 per cent, so the margins are quite small, and some branded prescribing will happen because products still have a patent. We should recognise that there is only a small margin for efficiencies. However, I support generic prescribing.

Gail Caldwell: I want to return to our discussion about shortages. At the end of last year, we introduced serious shortage protocols as part of the planning for exit from the European Union. There is now guidance whereby, if shortages escalate, community pharmacists can substitute drugs for certain conditions for certain patients. That might be a scenario in which we would want to have legislative power and a process available so that, if there is a serious shortage, we can maintain the supply chain for a particular type or class of medicine.

George Adam: I am aware that there are patents for branded medicines. My wife has multiple sclerosis, so I have heard about all the various wonder drugs that have come along for MS, under branded products. However, if we started talking about how drug companies come

up with their costs, that would open up a whole different can of worms.

I think that Gail Caldwell's answer was along the lines that generic prescribing is fine as long as it is correct for the condition that is being dealt with. I assume that, in asking for that, Community Pharmacy Scotland is assuming a degree of professionalism. Obviously, pharmacists are going to prescribe things that are correct for individuals. I cannot see a pharmacist, in the example that you gave, prescribing something different that would not help the individual, so I am trying to work out what your answer really meant.

10:45

Gail Caldwell: I will try to answer in a different way. I support generic prescribing and the use of generic medicines where that is safe and appropriate, and I am sure that most of my colleagues in community pharmacy, primary care and hospital pharmacy would also support that. Angela Timoney articulated the fact that branded products have patents and said that it is clinically appropriate to continue their use in the case of narrow therapeutic index drugs.

I am looking to my right in the hope that Campbell Shimmins will come in but, professionally, we support generic prescribing and generic dispensing where that is safe and appropriate.

Campbell Shimmins: I totally agree with everything that Gail Caldwell has just said. There is probably a bit of conflation in our request with the serious shortages in England and what we faced two or three times last year and will face again at the end of this year, because there is the possibility that the medicines supply will be interrupted. Our request was in that context. To reinforce what Gail Caldwell said, when a medicine goes out of patent, nobody in Scotland is quicker than the health boards at switching to a generic drug as soon as possible. The potential efficiencies there are very limited because the boards already manage that so well. Our request was about serious shortages and emergency supply situations.

David Stewart (Highlands and Islands) (Lab): Good morning, panel. I will ask a few questions about hospital expenditure on drugs. Why has expenditure on medicines in hospitals grown at a much higher rate than general hospital costs?

Gail Caldwell: Medicines expenditure in the NHS now represents about 17 per cent of boards' spend. We are seeing the proportion of that spend increasing in the hospital setting. That is partly really good news for patients, because we are seeing a lot of new medicines coming through for cancer, MS and ophthalmology that offer significant benefits. We have, for example, seen expenditure on cancer medicines grow by 133 per cent. That is about offering patients more effective options and choices.

From a board perspective, one of the challenges is the access to new medicines and the flexibility that has been applied to that. We now see in boards increased access to medicines that we traditionally might not have considered to be cost effective, in line with our health technology assessment process. Through the changes to the policy position in Scotland, boards are now making available medicines that we would consider to be no longer cost effective. That has an impact in that it diverts resources away from other interventions that we might consider to be cost effective.

I will make a point about how we see medicines as part of the overall pathway of care, which is based on my awareness of work in NHS Ayrshire and Arran. This is slightly tangential, but the management of chronic obstructive pulmonary disease uses what is called the COPD value pyramid, which puts medicines in the context of other interventions that are more cost effective. We know that, for COPD, giving patients flu vaccinations and access to smoking cessation and pulmonary rehabilitation services is more cost effective than medicines, and delivers better outcomes than medicines do. How we see medicines in the overall pathway of care is an issue for me.

David Stewart: Sure. I will get the other witnesses' views on that shortly.

What Gail Caldwell said is interesting, and I do not necessarily disagree with any of it. However, let us look at a bit of history. If we go back over the past six years—I thank the Scottish Parliament information centre for this information—and look at the compound average growth rate in hospital drug costs, we see that it has been 6.6 per cent, which is miles higher than the normal inflation rate. I am aware that the general inflation rate in the NHS will be higher than the inflation rate, but I will put that to one side just now. All hospital costs have gone up by 1.5 per cent. There is a horrendous difference between that and 6.6 per cent. As you will know, the committee looks at all the territorial boards and others. We have found that one of the big factors in brokerage in boards—some of our witnesses can talk about that—has been the massive growth in drug costs in hospitals, to the extent that the costs are almost unmanageable.

As I said, I accept everything that Gail Caldwell said, but is there an issue around management control and efficiency that we also need to look at? Frankly, some of our boards in Scotland—I say this because I am worried, but there is a lot in it—

are financially unsustainable, and drug costs are a factor.

Professor Timoney: Perhaps I can describe to you what we do in the acute service in NHS Lothian to try to manage our drug costs.

David Stewart: Sure.

Professor Timoney: I fully support everything that Gail Caldwell said about some of the reasons for the increase. We need to recognise that, with the increase in throughput in hospitals—people are going through them more quickly—more people, including frail elderly patients, will be on more drugs.

For the past seven years, NHS Lothian has had an acute prescribing forum, which meets once a month. It is co-chaired by the medical director for the acute service and my associate director of pharmacy. Each month, we meet two groups from clinical areas, and we ask them—doctors, pharmacists, business managers and finance managers from the areas—to describe the budget that they have for their area, the drug use trends and compliance with the formulary, and to say whether they are expected to stay within budget and, if not, what steps they are taking to address that. We also work across the service to manage switches to biosimilars and home care. As a result of that, NHS Lothian has saved £24 million of its drugs bill in the past seven years. That is an average of £3.7 million per annum, and that has helped us to contain our drug costs. It is not much good saying this, but they would be much bigger if we were not doing all that work.

Lots of work with our clinical staffing groups is required to make sure that we are clear about the reasons why we are using drugs, why we are looking at high-cost drugs, and why drugs are or are not on the formulary.

The medicines are coming through and, in the hospital service, we are more likely to use newer brand drugs. There is a cost associated with that.

Gail Caldwell: Angela Timoney is right: a lot of work is being done in the boards to manage the costs of medicines in acute care, and that is a challenge. I will give members a few examples and build on the point about the role of national procurement, which the committee explored earlier.

NHS Greater Glasgow and Clyde's costs for hepatitis C medicines have gone from £22 million to £7.5 million. We have driven down the costs of the medicines while treating more patients through effective procurement strategies, buying power and national consistency in how we treat those conditions.

Angela Timoney mentioned moving from biologics to biosimilars. That has required careful handling of patients, including conversations about switching from one biologic for their rheumatoid arthritis, for example, to a biosimilar, but it has saved our organisation £6 million in one year.

We can give members lots of examples of how boards are managing the increase in expenditure on medicines, but the policy position on increasing access to medicines is also impacting significantly on our acute service.

David Stewart: All those examples are excellent, and it is good to see some of those initiatives being rolled out across all 14 territorial boards, because we have picked up hints of a postcode lottery, with only some boards doing excellent work. There is a certain problem with overspend, which causes issues around brokerage, as the witnesses well know.

I have another question—maybe some of our other witnesses can come in on it. I am conscious that I might be comparing apples with pears, but the growth rate in primary care drug costs over the six to seven years was 3.6 per cent, compared with 6.6 per cent in the hospital setting, and all primary care costs went up 2.3 per cent. The hospital is quite a different environment in terms of costs. Are there any comparators that we can use there? Why is there less inflation in the community setting than in hospitals?

Campbell Shimmins: The issue is much more complex than prices across the board. When I started in pharmacy 25 to 30 years ago, it cost £500 million for a pharmaceutical company to bring a drug to market. Now it costs £1.5 billion to £2 billion, and the companies have the same amount of time to recoup their research and development costs and make the margin. Research is incredibly expensive, and costs have gone stratospherically high.

In primary care, we are dealing with 85 per cent generic prescribing, and it is easier for us to bring down costs in areas in which medicines are no longer under patent. They and their safety profiles are well understood, so we can use them much more widely and effectively. It is easier to get compliance, concordance, adherence and reduced adverse drug reactions—or ADRs—because we are so familiar with the drugs. They have been out for 10, 15 or 20 years. The hospital service does not have that, because it deals directly with pharma on branded products. Companies are innovating, and pharma—rightly or wrongly—has massive development costs to recoup, as you have described. The hospitals have to work with that, and the exponential increase in costs has run away from inflation, for obvious reasons.

For me, that is the difference. We are not doing things differently; we have the same area drug and therapeutic committees, the same governance

approach and the same robustness, and we have regular meetings at which people ask, “Why are you prescribing there?” and “Why has that general practice got an anomalous spike?” We do the same things as the hospitals, and we manage costs in the same way, but we deal with a different animal to one that the specialist centres deal with.

Emma Harper: I have a supplementary question about the hospital costs of medicines. Anaesthetic drugs sometimes cost a lot more, and we have a faster throughput of patients through day surgeries. Isoflurane is a cheap anaesthetic drug, but it makes people nauseous, so other medicines have to be given to deal with that. If we use other drugs, such as sevoflurane or desflurane, patients can get up and out pretty quickly, but they are more expensive. Do short, intensive care unit stays and total hip and total knee replacements—get them in, get them out—contribute to hospital medication costing a lot more?

Gail Caldwell: That example is very specific and describes how we consider the costs of a medicine in the overall pathway of care. If we were to use the older anaesthetic agent with more side-effects, patients would spend longer in hospital because they would need other supportive treatment, as you rightly said. There are also increased risks, such as infection, so we need to look at our choice of medicine in the round. Your example may be a good example of using a more expensive medicine, because the overall benefits—for length of stay, risk of patient harm and side effects—are more positive with newer, more expensive medicines than with older ones. We assess all of that as part of the pathway approach.

Emma Harper: Patients report that one of the worst complications is post-op nausea and vomiting. They do not complain about pain, because they know that they will have it, but they say, “Nobody told me that I was going to be sick.” That is why anaesthetists put a lot of energy into reducing the complications that increase medicine costs.

Gail Caldwell: Yes.

Emma Harper: I will go on to ask about patients’ meds in hospitals. For elective surgery and admissions, patients are told to bring their own medication. Sometimes they are prescribed other medication when they are in hospital and they are discharged with lots of meds, including new ones, which sometimes leads to duplication. Some of the submissions to the committee called for the better transfer of information between community and secondary care to reduce the waste that is caused by that duplication. What needs to be done to avoid the unnecessary prescribing of medicines to patients on admission and discharge and to avoid such duplication?

Gail Caldwell: Scotland’s hospitals have systems to encourage patients to bring in their medicines, because they are an important source of information and tell us a lot about what patients are taking. In the elective setting, we encourage patients to bring their medicines into hospital, as you have described, and we often use the medicines when patients are in hospital.

You have raised an important point, because duplication of that supply could be a risk. We might use those medicines during the patient’s stay, if they are of good quality—we have assessment processes for that. The patient would then take those medicines home with them, and we would give them an antibiotic or painkiller on discharge. That helps with continuity of supply. It also helps that the medicine is familiar to the patient. We do not want to give the patient the same drug that just looks different, because that might lead them to wonder whether it is a different drug and think that they should take it twice.

In the elective setting in particular, it is important to encourage patients to bring in their own medicines and to use them during the stay, and then to supplement them with any additional medicine that is required when the patient goes home. That is a safer strategy.

11:00

Jonathan Burton: Much of that is what we would call medicines reconciliation, which is basically making sure that people have the right medicines with them. When they move setting—into hospital and then back into the community, for example—we ensure that those medicines are checked so that nothing is missed or duplicated and they do not end up taking something for a long period when it should have been stopped quickly.

Pharmacists and, increasingly, pharmacy technicians work really hard at meds rec—that is what we call it—and it soaks up a lot of resource. That goes back to the interoperability of our systems and the lack of a universal patient record, which means that we have to check things again and again and patients are asked the same things again and again.

Some health boards have made more progress than others. We have done a lot of work on the discharge process and ensuring that, if patients have complex mixes of medicines and a tray with their medicines that needs to be pre-prepared, which requires a lot work, there is good communication from our hospital colleagues with the community pharmacy. A lot of that used to be done by fax, but it is increasingly done by email.

HEPMA will help with that. The more connected we are, the better.

Some of our community teams will pick up the baton by taking on a certain amount of that medicines reconciliation. It is a key task for our pharmacists who work in GP practices. That has been very helpful in shifting some workload away from busy GPs. However, we are all under pressure, and a certain amount of that workload should not be there in the first place. If we were all better connected, we would not have to check things so many times and we could have more valuable conversations with patients about how they feel about their medicines and how they are taking them, rather than just being able to check whether what we have got in front of us is what we were expecting and that nothing has changed.

Emma Harper: Is HEPMA moving forward fast enough? Given that it is an electronic database that enables the different areas to talk to one another, it would seem to be a great way of reducing waste and supporting conversations and communication.

Gail Caldwell: Fairly recently, the Scottish Government confirmed funding for boards to implement HEPMA across Scotland. As I said earlier, several boards have already implemented it. I am co-chair of the HEPMA implementation oversight board. We have made a commitment in the first quarter of this year to provide an update on implementation across the whole of the NHS in Scotland.

The Convener: Gail Caldwell said that medicines that patients bring into hospital are used as long as they meet a quality test. Previously, in reply to a question about medicines being returned to the pharmacy or coming back to a setting, you said that you would not consider using such medicines because you would assume that the quality could not be verified. What is the difference?

Gail Caldwell: Well spotted. First, when a patient brings in medicines from home, we give that patient the same medicines that they have been using at home. I am not asked, as a professional, to give that medicine to another patient.

Secondly, we have very tight assessment processes to ensure that the medicine is in date and has been stored correctly. We would talk to the patient, especially in an elective situation, such as in a pre-admission clinic. We would sit down with them and review the medicines to ensure that they are of appropriate quality so that the patient for whom the medicines were dispensed can continue to take them during their stay.

The Convener: Okay.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning. I have been following the evidence this morning with some interest.

I will ask about community pharmacists—the question relates to costs, as well. We all know that they are independent contractors to the national health service, and that a large part of their remuneration is based on recompense for dispensing medicine. They receive a fee that is not just a mark-up on the product that they dispense but is also for the act of dispensing. Some submissions that we have received argue that that creates an incentive to dispense medicines at the expense of non-pharmaceutical interventions, and they call for a change in the contract in order to incentivise pharmacists by remunerating them for medicine reviews and similar sorts of care, and for de-prescribing.

Does the panel believe that the current pharmacy contract contains perverse incentives for community pharmacists to dispense medicines, and that it therefore creates a barrier to their exploring non-prescription alternatives?

Campbell Shimmins: That was perhaps the case up to a decade or so ago. We have been moving funding out of the drug tariff into our global sum, and redistributing it for care packages and additional services. It has long been recognised that reimbursement and remuneration through the tariff alone is not a sustainable position.

In 2006, we were funded only for dispensing. Now, 15 years later, we are funded for our acute medication service and our chronic medication service, we have a public health service and, of course, we have the minor ailment service that is about to transition to Pharmacy First.

It has been recognised that we are moving towards the important factor being the quality of interventions and supply. That makes better use of us as clinicians and as pharmacists. It is hoped that that will also enable us to retain staff whom we have spent a lot of money training, and help us to resist some of the transition to other areas of the workforce that we have heard about, by making the service more clinical.

It has been a long and slow journey. As I said, in 2006, we were reimbursed purely for dispensing: that was all that we did. We are contractors, as are GPs, and we recognised a long time ago that that position was not sustainable. Not only that, but we saw that it did not reflect our skills or where we wanted to be in terms of the advice that we give and the observations that we make. As was mentioned, the recording of outcomes is not great, but that will improve—it started to improve with the minor ailment service. That service has been studied and is, basically, the envy of the world.

For the past 15 years, we have been mapping money away from the tariff and putting it into services. That process will continue, and you will probably see it happening—certainly, boards will see that being reflected in their drugs bill in the coming year or two, as has been mentioned already.

I accept Alex Cole-Hamilton's point, but we have been changing and are now miles away from where we were previously.

Alex Cole-Hamilton: Does the contract need to be revised?

Campbell Shimmins: The contract is being revised; it is evolving. "Achieving excellence in pharmaceutical care: A strategy for Scotland" has given us a pathway on which pretty much everybody agrees. However, at issue is the time that it takes to deliver services. A lot of information technology is involved in development of the minor ailment service, and there are a lot of known unknowns in respect of how patients will react to it and how they will use it. We have had to pilot a lot of things, and all that takes time.

We also have to develop an evidence-based formulary, which we are in the process of doing. It is just about ready, although nobody has seen it yet. We need to make sure that the evidence is fully formed and that it gives value for money.

I think that there used to be a perverse incentive to dispense. One of the things that was suggested 10 years ago was that there should be an incentive to de-prescribe. I think that that is part and parcel of the MCR—medicines: care and review—service that is being developed. Pharmacists will not be remunerated specifically for de-prescribing, but their doing so will be part of their behaviour as clinicians. That is our future, because it is what the kids coming out of university want to be doing.

Alex Cole-Hamilton: I have a supplementary on that issue. Nothing is written down that says that pharmacists will be remunerated for de-prescribing, but we have heard many times in the inquiry about the benefits of de-prescribing and reducing polypharmacy, in particular for older and infirm citizens, who in some cases are being harmed by the range of medications that they are on because nobody has reviewed it for a while.

There is a saving attached to de-prescribing, including a massive saving in terms of potential preventative work that stops people getting ill or makes their quality of life better. Is there a calculation that we can use to incentivise pharmacists by having them share in that saving? Could they be incentivised to de-prescribe by identifying the costs that they save, of which a small amount could be returned to them?

Campbell Shimmins: Absolutely—if the civil service and its negotiators are willing to go down that route. The technology and the information to do that exist. I am not sure whether that would be subsumed into a bigger picture, because there are lots of elements to pharmaceutical care, and de-prescribing is just one of them. However, I absolutely support such an approach—in recognition of the benefits and in opposition to those who say that we are incentivised to dispense, because that does not sit right with me as a professional.

Professor Timoney: I have a few concerns about remunerating people for de-prescribing. The risks of incentivising de-prescribing are the same as the risks that we have just heard about with community pharmacists dispensing because they are incentivised to dispense. We should move away from incentivising and towards a neutral effect. We should be rewarding high-quality care, which is what the contract has been moving towards.

I endorse what Campbell Shimmins has said: the situation has changed dramatically in my lifetime, as a director of pharmacy. Now, community pharmacists are paid professional fees for their services. I would like to see us moving further along that track, such that we reward pharmacists for good practice, and that is not linked to whether there is a prescription. The pharmacist will consider what is best for the patient and will not be incentivised not to prescribe, and the patient will get what is best for them.

We know the problems with polypharmacy, but the reality is that frail elderly patients change very rapidly. They might stop needing a medicine at one stage, but might very soon need it again. We need to help them to understand their medicines better, rather try to incentivise de-prescribing.

Jonathan Burton: I have been a community pharmacist in Scotland for about 20 years. Our contract has evolved; we can argue about the pace of change, but it has been continuous. The contract that we work with now is almost unrecognisable compared with the one that I originally worked with in 2000-01.

There will always be, quite rightly, a lot of debate around the funding model for a profession that is based on a contractor model. We are similar to optometry, dentistry and general practice in that regard. The RPS has always argued for more transformational change in the community pharmacy contract in order to support pharmacists and their teams to focus on the care that they deliver to patients. To a certain extent, our contract is already moulded around that principle.

The argument about incentives for dispensing, and the fact that part of our payment structure is still attached to purchase of and reimbursement for medication, can be flipped on its head. We can look instead at whether contractors and pharmacy practices are reimbursed effectively for the volume and workload that they manage.

The missing bit of the jigsaw puzzle is how we ensure that, when we are reimbursing for the supply of medicine, the additional value is always accounted for. We are always talking to the committee about the additional value that pharmacists bring through their conversations with patients, oversight activities and so on. Up to this point, it has been difficult, because of lack of IT and how the contract is developed over time, to prove that added value by quantifying and recording it. However, we are getting closer to the point at which we can build a really good evidence base, ensure that there is good visibility for the great work that goes on around dispensing, and incentivise pharmacists to engage with that and be consistent in it.

The public deserve to get their medicines and all the additional benefits of getting them from our community pharmacy network. However, the contract should compensate pharmacists for the workload and the number of patients that are seen. We need to be better at ensuring that. It is about the visibility of the quality that we offer, as professionals. A lot is lined up for that; for me, that is the next evolutionary step in respect of our contract.

11:15

The development of Pharmacy First will to create more visibility of the consultation model and of what we can bring to it. In theory, there is no reason why we cannot replicate some of that in our dispensing services.

Brian Whittle: The chronic medication service is intended to help people with long-term chronic conditions, but it has faced some criticism because of the idea that it increases unnecessary repeat prescribing. Does the chronic medication service exacerbate unnecessary repeat prescribing?

Campbell Shimmins: The short answer is that it should not, because the CMS is designed to rationalise and optimise a patient's therapy. We need to build conversations with patients. Medicines should not be layered without having conversations and ensuring that there is a need for them, and that the patient is utilising them properly.

The CMS should not increase use of medicines—if anything, it should stabilise it. We are not making clinical decisions on prescribing, so we are not driving use of the medicines. As experts in medicine, we are there to question prescribing.

Based on experience from my practice, I am inclined to say that we probably see less prescribing with CMS than we do with any other form of acute prescribing.

Gail Caldwell: I will build on what Campbell Shimmins said, and on what has been said about the move towards the MCR service in serial prescribing. As I said, that is designed specifically to encourage conversation with patients at the point of dispensing, and to ensure that there is no waste and that medicines are supplied when they are not required. MCR will continue to build on CMS to encourage a reduction in waste and create more effective systems.

Brian Whittle: David Stewart and Alex Cole-Hamilton touched on COPD. Is the default position to medicate when other alternatives might be helpful, but are unavailable to the general medical profession?

Gail Caldwell: I see your point. The committee will explore social prescribing; I know that it has heard about examples related to diabetes and smoking cessation. I come back to COPD and the most cost-effective interventions. If a prescriber, GP or clinician is in consultation with a patient who has COPD but does not have access to good pulmonary rehab services, their default position will be to write a prescription for medicine.

We need to ensure that medicines are placed in the overall pathway of care. If a patient has COPD, the most cost-effective things are flu jabs and smoking cessation services. We need to have a sense of the choices that GPs have in managing conditions. Brian Whittle is right that there is a tendency to write a prescription because alternatives are not available.

David Stewart: What assessment have panel members made of the minor ailment service?

The Convener: Campbell Shimmins, I think, said that the minor ailment service is an important part of the picture.

Campbell Shimmins: The minor ailment service has been a huge part of the picture. Community Pharmacy Scotland commissioned research from two universities and an independent researcher to assess the impact and value nationally of the minor ailment service. The outcomes were overwhelmingly positive. We would be happy to share the research with the committee; I cannot speak to it right now, because I do not have it in front of me. The minor ailment service is overwhelmingly loved by patients, too. The Scottish Government is piloting the service's expansion and—if you like—upskilling.

NHS Ayrshire and Arran has done its own research, which shows similar outcomes, although the board's angle was slightly different. I am sure that that work will be shared, too.

David Stewart: If I understand it correctly, eligibility is being extended to all patients.

Campbell Shimmins: Yes.

David Stewart: In general, do patients understand the scheme? Perhaps the research considered that point. The scheme seems sensible and important, but is it sufficiently understood and are enough patients registering for it?

Campbell Shimmins: It could be better understood, in the context of the national picture. The people who use it absolutely understand it, as do the people who manage and operate it. It is understandable that the service was not heavily publicised. A strategy needs to be in place as it develops, with a reinfusion of publicity about what the service is.

The service is loved by the people who use it. There is a slight anxiety about overpublicity and the wrong kind of publicity but, frankly, Scotland has managed the issue really well and I am sure that it will continue to do so. I am not part of the promotions team for the launch of the new service, but I imagine that the team will get the message spot on. The message needs reinvigorated.

Gail Caldwell: Community pharmacies in Scotland are perfectly and uniquely placed to support the assessment and management of common clinical conditions. David Stewart made an important point: we need to do more to educate the public and to signpost people so that we change their direction of travel when they are seeking help for common clinical conditions.

We need to look at how many of the common clinical conditions that are being presented through our hospital front doors and out-of-hours services, which become quite busy at times, could be safely and effectively managed through the minor ailment service and pharmacy first, and we need to build on that.

You are right to say that we need to help the public to make different choices, through better signposting, so that people are directed to their community pharmacies, especially the ones that offer extended hours. Some community pharmacies are open on Saturdays and Sundays and do late nights. We need to encourage patients to go to those pharmacies rather than to out-of-hours services.

Jonathan Burton: It is important to recognise that there has been independent research into the minor ailment service, which has generally found that the service has been very well received by the Scottish public.

We are about to go through the next evolution of the service as it merges with Pharmacy First, which is currently an additional walk-in service whereby patients can access assessment, treatment and referral for a slightly extended range of conditions. There are also pieces of research, albeit on a smaller scale, about the early Pharmacy First work, which in effect show exactly the same outcomes and public and professional opinions—that is, the service has been positively received. A smaller cohort of pharmacists, which includes me, have been through a slightly extended clinical skills pathway and are independent prescribers who deal with another layer of the onion, which is walk-in conditions. That approach is being further rolled out across Scotland.

I fully endorse and support the Pharmacy First approach—I am living, breathing proof of how it works; it is a big part of my daily life. Public education is key, and it is important to stress that Pharmacy First does not mean pharmacy absolutely first—what comes absolutely first is people knowing how to look after themselves when they have basic conditions and having medicines in their medicine cabinets. Pharmacy First is about people having their first formal point of contact with our health service at a pharmacy, rather than jumping straight into a general practice, an out-of-hours centre or an accident and emergency attendance. It is important that we frame it in that way.

I am excited about the next steps for Pharmacy First, but I will sound a cautionary note. There is also the risk that we will be swamped with work. That is why the context is important. We still need to focus on teaching people—early in their adult lives and as children—some of the principles of self-care. We need to work on that through schools and make sure that people do not access the service for everything all the time. We do not have the capacity for that. We need to see the right patients at the right time and be able to signpost them. Because the latest iteration of the service is being opened up to the whole population, that brings us a great responsibility to offer that service in an appropriate way and to signpost adequately; part of that is being joined up IT-wise. That is important. We will be able to max out the benefit of that approach only if we are properly plugged into out-of-hours services and to our GP colleagues.

Professor Timoney: I will reiterate something. You asked about evaluation and we talked about the fact that an evaluation was done by two schools of pharmacy. We also did a small evaluation in our health board of the new

Pharmacy First service for impetigo and urinary tract infections. Out of 1,000 consultations, 90 per cent of those were handled in the community pharmacies; they could deal with the patients. A couple of cases were urgent and required referral to out-of-hours services. A few patients saw their general practitioners the next day. We have clear evidence that Pharmacy First works.

David Stewart: I will speak briefly. On a naive level, it is a punchier title; I do not know who is responsible for advertising the scheme. On a serious point, in previous evidence, we heard that people in lower socioeconomic groups sometimes do not approach primary care in a way that we would want. I hope that the new service will allow more difficult-to-reach patients to access pharmacy first in the longer term.

Campbell Shimmins: I agree.

Emma Harper: I am interested in some issues to do with online pharmacies. Pharmacy2U is one of the most important. It also has online doctors who can prescribe. I am interested to know whether distance dispensing poses a threat to community pharmacy and good pharmaceutical care. Where is the face-to-face aspect of that? How are we regulating it? The service is regulated by the Care Quality Commission, and the United Kingdom-based doctors are registered with the General Medical Council. However, if a doctor prescribes antibiotics, do they not first have to measure the patient's vital signs in order to make a baseline assessment?

Campbell Shimmins: England is going down a different route from Scotland, where health is a devolved matter. Scotland's direction of travel is about face-to-face consultation in communities and accessibility wherever it is possible. Online offerings are appropriate; that is a fact of life and a direction of travel, but we have to be able to offer a whole package. In Scotland, we have to offer the public health service, Pharmacy First, serial dispensing, serial prescribing and medicines care and review. A lot of those things are not impossible to reflect in an online offering and maybe one day technology will get there but, at the moment, it is about the bricks and mortar in those communities. Yes, there is a threat but all competition is healthy in some respects. However, our direction of travel is more about the practitioner, the clinician in the community and face-to-face consultation.

Emma Harper: Some of the face-to-face work could be done digitally. We already have online engagements through the attend anywhere service. Online serial dispensing could also be about catheters and colostomy products. At last week's committee meeting, I mentioned that medicines are not just about the tablets but about other repeat prescriptions, such as testing strips for type 1 and type 2 diabetes, as well as the colostomy products and catheters.

It is a concern; people can get their repeat prescriptions digitally but face-to-face consultations are a continued way of assessing patients' adherence to the medicines.

11:30

Campbell Shimmins: They are a way of assessing adherence and concordance, finding out the patient's history and taking a holistic view of the patient. Those things are extremely important and patients cannot get them online. They have choices and tend to vote with their feet. The service here is constructed to be a whole service rather than taking it in bits. We could zap a prescription over and it would come through the post, but we would then lose a local intervention opportunity. There are risks and dangers, but that is not the direction of travel in Scotland.

Professor Timoney: The points that you have raised are important. The directors of pharmacy met the General Pharmaceutical Council recently to discuss online pharmacies and how it regulates them. It has raised its concerns with us, but it is not particularly an issue in Scotland. You spoke about people getting some medicines that might be helpful, but it is saying that people are tending to try to get opiates, antibiotics or lifestyle drugs. There are risks and issues in Scotland, which we are working closely on with the GPhC.

Healthcare Improvement Scotland also has a responsibility for regulation, and the directors of pharmacy meet with it to look at how we keep the system safe in Scotland.

Jonathan Burton: Campbell Shimmins raised points about how our contract has evolved in Scotland and the way in which it supports our pharmacy network and pharmacies in our communities. When considering online services and their potential impact on the greater pharmaceutical service across Scotland, we need to step back and think about what our community pharmacies are there for. Our pharmacies are there to supply medicines, which can of course be done through an online model, but they are also an integral part of our communities. The banks and some of the post offices have gone, but the pharmacies are still there.

If a patient needs help there and then but does not have a car, is perhaps not IT literate and has a young family, they can walk down the street, go to their pharmacy and speak to a health professional. In Scotland, we have actively made the choice to support that model. We have a lot of small pharmacies in remote and rural areas and in places where other businesses are not, such as deprived and inner city areas. They are part of the

social fabric of those communities and need to be cherished and looked after. That model has genuine social value and key advantages.

I agree that our regulator has started to be a lot more bullish. We have the Care Quality Commission and the GMC, which regulates doctors, but the GPhC has certain responsibilities to regulate the pharmacist and technician input into the online services. It has started to have a good dig around, and what it is finding is not pretty. A lot of the time, online services are not about supporting communities or patients but about selling medicines for the wrong reasons, quite frankly.

Emma Harper: The points about opiates and opiate prescribing have been brought up previously in England, because there was overprescribing with the potential implication that opiates were intended for further sales to others. I suppose the way to proceed is to make sure that safety or capping is built in, so that even if it is a higher dose of opiate for a person, it is intended for that person to use.

Professor Timoney: Yes, it is important to have checks and balances in the system. Apart from the work that all directors of pharmacy do to look at prescribing as a whole, many of us are also the accountable officer for controlled drugs for our health boards. We have a separate team that looks at controlled drug prescribing, not just for NHS prescribing but for non-NHS and private prescribing, to try to get a sense of what is happening. We meet with prescribers if we have concerns about their prescribing habits.

The Convener: I thank the witnesses. This has been a very full session. I apologise to members who were not able to get late supplementaries into the picture, but I am sure that we will hear more. One or two commitments have been made by the witnesses to supply research and other papers, which we look forward to seeing. The meeting will now go into private session.

11:35

Meeting continued in private until 12:02.

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