OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 18 February 2020

The Scottish Parliament
Pàrlamaid na h-Alba

Session 5

Tuesday 18 February 2020

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HEALTH AND SPORT COMMITTEE

4th 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:

Graeme Bryson (NHS Dumfries and Galloway)
Jonathan Burton (Royal Pharmaceutical Society)
Claire Fernie (NHS Fife)
Adam Osprey (Community Pharmacy Scotland)
Dr Sheuli Porkess (Association of the British Pharmaceutical Industry)
Dr David Shackles (Royal College of General Practitioners)
Adam Stachura (Age Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 18 February 2020

[The Convener opened the meeting at 09:30]

Medicines (Supply and Demand)

The Convener (Lewis Macdonald): Good morning and welcome to the fourth meeting in 2020 of the Health and Sport Committee. We have received apologies from Sandra White. I ask everyone in the room to ensure that their mobile phones are switched off or to silent mode. Although it is acceptable to use mobile devices for social media, please do not take photographs or record proceedings.

Under agenda item 1, as part of the committee's inquiry into medicines supply and demand, we will take evidence on consumption and waste from two panels. I welcome Adam Stachura, who is head of policy and communications at Age Scotland, and Claire Fernie, who is a public partner volunteer with NHS Fife.

We have heard a good deal of evidence on the importance of patients being involved in decisions about medication. As you approach the matter from a patient perspective, will you give us your views on the current state of play in that regard? Are patients involved regularly, or only rarely? How do things stand in relation to medication?

Adam Stachura (Age Scotland): It is probably a bit of a mixed bag across Scotland. It will depend on the conditions that people are living with. The big challenge around people being involved in decisions on medications is about the length of time that patients have with either a general practitioner or a pharmacist to discuss those decisions. Also, people may not even know that they have the right or are empowered to do that. That is not a criticism of GPs, pharmacists or whomever the patient discusses such decisions with; people might simply not be as informed as they could be about what to ask.

As I said, it is a mixed bag. In cities, people might not see the same GP more than once in two years—the next time they attend, they might see someone else. In rural areas, people might have more of a relationship with their GP or whomever they see in the practice. There can be different outcomes for patients depending on where they live.

The Convener: In your experience, it is a mixed bag.

Claire Fernie (NHS Fife): I agree with that. Some groups of patients, such as those with long-term conditions, can be very involved in and knowledgeable about their care, and they will be keen to ask questions. It is about people being able to take time to have those conversations and to think about making decisions when they are greeted with options. Traditionally, we are used to our clinicians telling us, "This is the right thing for you." We are not used to having to consider options. Occasionally, with the realistic medicines programme, we find that patients say, "I expected my GP to tell me what is best for me, because he's the expert. I don't know where I stand now."

The Convener: We are looking to increase patients' engagement and put them more effectively at the centre, but do you have a concern that some patients just would not want that?

Claire Fernie: That is true for certain groups. Patients who access much broader sources of information through the internet—young patients in particular—may already have a lot of information when they go to their GP, but there are still patients who prefer to say, "You're the expert and you can fix me. Tell me what to do."

The Convener: Can anything be done to address those issues? Should the national health service or prescribers be doing anything more proactively to encourage patients to engage?

Claire Fernie: Part of it is about education so that people know that they have the right to ask and that they should be asking, as Adam Stachura said. Part of it is about support so that people feel comfortable about speaking to their GPs. The Scottish Health Council recently produced a document about using patient aids for discussion. It found that patients are reluctant to contradict their GP if something is suggested, and that carers are not always included in the conversation—they might not even be in the room.

A lot of it is about making people feel comfortable enough to ask those questions in the first place and making sure that they understand the information that they get back. For example, there is no point in telling a patient the numbers to treat—that information will not necessarily mean anything to them.

Adam Stachura: I back up much of what Claire Fernie has said. We also need to think about the prompts that come from the GP and the things that they might say to the patient, such as "Does this all make sense?", "Do you have any questions about that?" and "These are the side effects of this medication".

The big challenge is the amount of time that GPs have with patients. If someone goes in to talk about a condition, there might be circa 10 minutes for them to talk about it and be prescribed something, depending on the culture. The GP needs the time, space and availability to ask the questions, rather than just saying, “Have you got all that? Off you go.”

There is a good point about carers and older people who may be living with early-stage dementia that has not been diagnosed yet having the time to process the information. There is some really good practice in other parts of the world where, after an appointment or diagnosis, patients are allowed time to sit quietly in another room to process what has happened before they leave with a script to take to the pharmacy. Equally, there could be an opportunity for pharmacists to be available for people to ask questions when they hand over a prescription. The pharmacist could also ask, “Do you know what all these things are?” In that way, there would be a doubling up of the information that the patient has already consumed so that they can make informed choices both at that time and in the future, if they need a repeat prescription.

Brian Whittle (South Scotland) (Con): We have heard in evidence that the default position is to medicate. What is the availability of alternatives such as social prescribing? For example, physical activity and a change of diet can be crucial to alleviating type 2 diabetes, and we have heard in evidence that the best treatment for chronic obstructive pulmonary disease might be smoking cessation or even a flu jab. Is that brought to patients’ attention enough? Do we have the capability to make such alternative prescribing available?

Adam Stachura: Social prescribing is not embedded enough across the country and individuals do not know that things are available to them. There need to be interactions with the health service so that there is a consistent approach.

It is really good that there will be a debate in Parliament this afternoon on the committee’s report on social prescribing. Age Scotland talks about it a lot. We have been trying to develop access for older people to the proliferation of walking sports—our chief executive has taken the lead on that. Walking football has taken off over the past 10 years, which is absolutely brilliant. There are endeavours with Netball Scotland to do more walking netball, and recently we have had discussions with the Scottish Rugby Union about the development of walking rugby. We have had discussions with the governing bodies of many sports about making the walking versions of their sports available so that, whatever people’s age or stage and wherever they live, they can take part in sports that they may have loved for their whole lives. When we speak to the players of walking sports, we find that their health has improved, their blood pressure has decreased, their social connections have improved and their mental health has lifted.

Right now, it is a bit of a mixed bag because, depending on where someone lives in the country, they might not have access to the things that they want to do. If we tell someone that they have to go and lose weight, it can be difficult for them. However, if we give them opportunities to do that in ways that they will enjoy, it will be much more fruitful. That is the big challenge. At present, there is not a big enough network of availability across Scotland and GPs do not consistently know where to turn to in order to have the equivalent of green prescribing for such things.

Claire Fernie: In Fife, we are lucky in that we have a good referral system for several conditions. Across our sports centres, we run something like 100 health referral classes a week. On the back of that, there has been recognition that less-fit groups and older people also need streams in mainstream sport centres for the classes that they want to attend, so that they are not put off by the people in Lycra.

Brian Whittle: I am put off by the people in Lycra. [*Laughter*.]

Claire Fernie: It is about people getting into sport and leisure and keeping fit and healthy throughout their lives. We do that fairly well.

However, medication is free, whereas, in Fife, it is not free for people to go to a referral class, so we have that barrier to start with. Such classes can be offered only in certain areas at certain times, and there might be transport issues. We also find that, when a GP sends a referral list to the sports centre, only about 50 per cent of the patients will take up the referral. If we have discussions with the instructors, we can raise that to about 70 per cent, because we can address people’s fears of the unknown and the fear that it might not be for them. They may not have been active for much of their life and they may feel that they cannot do it. If they have been unhealthy, that can be a barrier to people getting into exercise in the first place.

Mr Whittle mentioned diabetes treatment. According to Diabetes UK, we have 22,000 people with diabetes in Fife. We have started work with the east region type 2 diabetes programme and we are doing some of the Counterweight programme. That is coming in, but we have only 240 places for the year, so there is still a massive gap in relation to capacity and cost versus the ease with which someone can go to a pharmacy and get a tablet.

Brian Whittle: We are talking about empowering people to get to a point where they can at least partially self-manage the conditions that they are living with. What is your experience of people who go to a pharmacy or GP surgery with the expectation that some kind of magic tablet will sort them out being confronted with the alternative of being sent to the gym? What is the general reaction to that?

Claire Fernie: Older people and people with longer-term conditions who have lived with health problems for a while are perfectly willing to try something new. The problem arises when the suggestion is unexpected because someone has a short-term condition—or a condition that they think is short term—or a new condition.

It comes down to having the time to have the conversations and being able to say, for example, "We know that your chronic pain will be better treated if we send you for a combination of physiotherapy and other care, rather than giving you a tablet." As Adam Stachura said, however, people need to have the time, the communication skills and the confidence to have those conversations properly.

Adam Stachura: There are some simple examples of the challenges that people face in that respect. For example, someone might be prescribed medication for acid reflux, but the solution might actually be a complete change of diet. In that case, it might be that the relief that the medication brings for the pain and discomfort will override the urge to do the preventative part. That might sound terribly simple, but the health professionals that I have spoken to about this tell me that some older people will say, "Just give me the pill. I'm not going to change my diet. I'm 65, and this is what I've been eating my whole life."

It is a cultural thing. Such people may know that the change would be right for them, but they have the option of the pill, which makes it difficult for the GP or whoever is dealing with them to say, "I'm not going to give you that—you have to do this other thing." The GP might not say that because they are trying to do the best thing for the patient. There is a bit of give and take on both sides. Acid reflux is a good example because the immediate relief from the pain and discomfort of the condition may override anything else that would prevent it in the long term. There is a kind of magic solution for that condition.

The Convener: To what extent are social prescribing and non-medical alternatives available as preventative measures? You have given an example of how difficult it is to intervene when someone is already unwell, but are those things used at all as preventative measures? Are patients keen to have access to them?

09:45

Adam Stachura: It is interesting that, once there has been a first social prescription intervention—for example, for the patient to take part in a walking sport—people see the benefit of it. Once they have been immersed in it, have lived it and are used to it, they wonder why they have not been doing it their whole life. Such things can help to decrease blood pressure and improve mental health, mobility, strength and balance. However, because of the lack of mapping of everything that is available out there—things are pretty disjointed—it is difficult for people to know where to turn to in the first instance.

At Age Scotland, we have a service called community connecting, which largely targets people who have no one else in their lives, are lonely and are looking to have more connections in order to tackle that loneliness or isolation. They can phone our helpline and have a discussion with somebody who will work with them for a number of weeks to look at the things that they might be interested in and the transport options in order to have the person embedded in a group. That service is hugely successful. The challenge lies in making sure that the right people know that it exists so that they can take the first step of making the phone call. Hundreds of people have been positively impacted by the service, which tells us that it is a good thing, but making sure that people know the details of where they can go to is a big challenge. The information cannot just be put on the internet somewhere, because there are people who are not online.

Emma Harper (South Scotland) (SNP): Adam Stachura talked about community connections, and we are talking about social prescribing. The term "social prescribing" has been around for a long time, but other people use different language when they talk about community engagement and how to tackle isolation and loneliness. Two weeks ago, we had a debate about singing to help with pulmonary rehabilitation. It also helps to tackle isolation and loneliness. What language are people more comfortable using? Do they know what social prescribing is?

Adam Stachura: Some people, particularly those who are engaged in such debates, will know what social prescribing is, but I wonder whether, if you asked 10 people in the street what it is, they would know. There is no doubt that, across Scotland, a lot of great things are happening with regard to getting people more active, looking at alternative medicines, and helping people to be more connected and less lonely. However, it is about how those things become more joined up, having consistency in language and leadership, whether that is from the Government or members of the Scottish Parliament, and using common language when we are talking about such issues.

One of the big challenges is around what to call it. If you talk about tackling loneliness, you often find that that has such a negative connotation that people do not think that it applies to them. The term “social prescribing” might sound too technical for what is happening to them. A group or organisation that does such work might prefer to call it something that is more common or appealing. Therefore, I do not necessarily think that using a blanket term would be the solution, but there is a lot of good practice happening all over the place, and you could probably map it all and call it the same thing, as you alluded to.

Claire Fernie: We are rolling out schemes in different localities in Fife. The public decision was to call each one “the well”. The idea is that, at a particular time in the month, a person can go along and there will be people there from the national health service, the social care partnership and voluntary organisations. If the person has an issue relating to housing or access to healthcare or if they want to get into exercise or they have a dietary concern, those people can signpost them to the right place to get into the system. As Adam Stachura said, “social prescribing” is a very technical executive term that is not commonly used. A lot of it is about getting access to services and knowing where to find them in the first place.

To go back to what Adam Stachura said about the social aspects, we are finding with the fitness classes that we are a victim of our own successes. People really enjoy them, they get a good social vibe from them, and they form communities. Therefore, we are now setting up social cafés so that people can spend time outwith the classes, otherwise, people would just not move on. We want to get people to a level of fitness at which they will move on to more mainstream activities, although there is also a gap there at the moment.

On interventional treatment, some of our trainers go into care homes to do armchair exercises, for example. Such things improve mobility, improve social groupings, and just make that little bit more of a difference. However, we do not really think about preventative care. We are still working at the point of need.

George Adam (Paisley) (SNP): I want to follow on from Adam Stachura’s acid reflux example. Is it not the case that, for a lot of GPs, medication is the easy option because it means that they will have control of the situation? It is human nature; we automatically want to control the situation. If they are to try social prescribing and leave a patient to another organisation to deal with, the professionals need to trust that those organisations will do what is needed.

In Paisley, St Mirren FC community trust has the football fans in training—or FFIT—programme, which people understand. There are variations of that throughout the country. I do not know of many doctors who would prescribe that programme for a patient, but it is probably better for a lot of people in the long term. That goes back to Adam Stachura’s argument about reflux. The long-term outcome would be better than the quick fix.

Adam Stachura: You are absolutely right. We definitely need to think about your first point about the immediacy of the GP looking at the challenge in front of them and deciding how to fix it. That will be down to their best judgment and will probably be the right thing to do. To use the example of acid reflux, the GP will do that or prescribe this, but moving the patient from withdrawal from the medication to changing their diet is their biggest challenge. A person lives with the pain to begin with and then has the magic pill or solution. It is then about removing himself or herself from that and doing the right thing.

The FFIT idea, which George Adam mentioned, is a long-term solution, and the preventative agenda is not talked about enough. Investing in prevention is not in a lot of what we deal with in the health world in Scotland, because it is difficult to prove its worth. If something has not happened, we cannot show that it has definitely not happened and what the financial cost would have been, although every study will say that there will be a massive saving in the long term.

We have seen an example of a GP socially prescribing someone a football season ticket because it was great for that person socially, for example. Of course, that person could afford it.

George Adam: As a St Mirren fan, I add for the record that that might not be good for a person’s mental health. [*Laughter*.]

Adam Stachura: I cannot necessarily say whether that was a Paisley GP, but some members of my family grew up in Paisley, and I think that they would agree with you. It might have been good for the social part of the patient’s life, but it might not have been good for them for the 90 minutes in which the game was being played.

That kind of thing has happened, and there are certainly pioneers across Scotland who will do such things. That means that there is joint learning about what works.

The big challenges are access to and the cost of the social prescription. I do not want to get dragged into this too much, but there are 150,000-plus pensioners in Scotland who are living in poverty, and they cannot afford such things anyway. Free prescriptions are their lifeline; they allow them to live well and to manage their conditions.

How access to groups and social activities is funded also needs to be considered so that it can be available and will be there for the long term. We always have the challenge of making sure that community groups, organisations and other things that are funded centrally or locally or by whatever are there for the long term. Once they have gone, they are hard to replicate.

Alex Cole-Hamilton (Edinburgh Western) (LD): Before I move on to a different topic, I want to talk about access to medicines. Adam Stachura mentioned the fact that many older people are not online. We know that charging has started for some home delivery services—in some cases, it is as much as £60 a year—but those services can be circumvented if the patient has internet access. We know that 500,000 older people in this country do not have that access. To what extent will that be a barrier to older people affording to access the medicines that they need, especially considering the charges that are coming in?

Adam Stachura: You took the figure right out of my mouth. Half a million older people in Scotland—the population of Edinburgh—are not online. Hundreds of thousands of people have nobody in their lives to help them to get online. That relates to issues including patients being informed about their medical needs and researching beforehand.

On home delivery prescription services, last year, Boots started charging the best part of £60 a year, or £5 for each prescription. Of course that is a barrier to people, and we know that great groups across Scotland, such as the Dundee Pensioners Forum, have been campaigning against that. They think that it is a bad move. Now that that charge has started, other pharmacies might find that they are open to doing the same thing. People who are on low incomes, live in remote places and have limited mobility and access to services might not be able to afford the medication that they need. The danger is not overprescription; it is underprescription, because of the conditions that are required. We can say that it is only 60 quid or £55 or £5 a go, but for a lot of people, every pound helps. Those people have among the lowest incomes and the poorest health. It is a retrograde move. It is a private decision, but Boots and other companies should reconsider it.

Claire Fernie: I echo what Adam Stachura said. That charge is a barrier to access. We have various waste problems that are related to repeat prescriptions and their monitoring. However, anything that stands in the way of the patient easily accessing their prescription is a bad thing.

Alex Cole-Hamilton: The other area that I want to talk about is polypharmacy. We know that two emerging agendas in health in this country are helping to reduce prescriptions: realistic medicine and deprescribing, or having regular medical reviews, so that people can assess what is still doing them good and what they are parked on. However, that approach does not seem to be universally applied. Some health boards still spend far more than they need to spend on GP prescribing, because they are not deprescribing or having those reviews. How can we get a consistent approach? How can there be discussions with older patients about the number of medications that they are on and the impact that having a review and divesting themselves of some of the drugs can have on their quality of life?

Claire Fernie: We can broaden out who holds the conversations. We tend to say that it has to be the GP, but we now have GP pharmacists in position, and a number of them would like to practise medicines reviews. That does not happen across the board yet, but that is the way that we hope the contract will go. Community pharmacies are also a good place to have conversations about the use of medicines, whether people are taking things and, if not, why they still get them dispensed. However, we must also remember that the pharmacist would not necessarily speak to the patient. There is the issue of communication and ensuring that the right messages get to the right people.

Adam Stachura: Last year, our sister charity, Age UK, produced quite a good report entitled “More harm than good: Why more isn’t always better with older people’s medicines”, which looked at overprescription and polypharmacy among older people. It covered England only, but we echo the almost zero tolerance approach to inappropriate polypharmacy. The patient’s expectation is that those who treat them or help them should know about that and that they should look at every opportunity not to prescribe.

The average care home resident is on more than seven types of drugs, and half—if not more—of the people who are in care homes live with dementia. When they have been deemed not to have capacity, how many of them are in a position to answer questions about what is going on and to have those proper and full discussions? The older people get, the more medications they are on. The easy prescription might be to give them drug 4 to counter the side effects or nausea of drugs 2 or 3 for a different condition. Those things start to mount up. That is not something that GPs will particularly want to do. That goes back to Mr Adam’s question about how GPs deal with things that are presented in the time that they have available.

10:00

Medicine reviews are absolutely critical, and they have to be consistent. I know of people who have undergone a private medicine review when they have been on holiday in Canada. That takes a couple of hours, and it is a fuller and more holistic approach. They are told about the medication that they have and what they can do to counter something, so they will not need to be on that medication. I am pretty sure that folk who sit there with pill boxes every morning and have never thought that they would be in such a position would love not to have to consume as many medications as they do.

Alex Cole-Hamilton: I have a brief follow-up question. How often are those medicine reviews broadened out to be more like therapy reviews rather than just pharmaceutical reviews? I ask that because there might be cases of people—I have a constituent for whom this is a problem—who do not have access to comprehensive and adequate podiatry. My constituent is not very stable on her feet and she spends a lot of time sitting in a chair. That sedentary lifestyle has led to a range of comorbidities. If she had had access to appropriate podiatry, she would be a lot more able and active. Are those two things linked together when reviews are undertaken?

Adam Stachura: From the experience that we have of speaking to older people more broadly, they would certainly welcome that. The podiatry point is interesting in relation to the change in how it has been used and funded in the past. There will be lots of older people who have less access to that.

I know that Mr Cole-Hamilton has been a big advocate of a national falls strategy and that kind of preventative agenda to tackle trips and falls and the conditions that can happen as a result. Lots of things can happen, such as being stuck in hospital because of the atrocious levels of delayed discharge that we have and not getting the right care afterwards at home. All of those things are linked.

There is a big cost to the taxpayer, but there is also a human cost. Last year, the committee published a brilliant report about delayed discharge, which said that people who are stuck in hospital for three weeks longer than they need to be can age 30 years. That is a devastating figure. Those are people who will probably never be able to recover and leave.

Having a broader approach not just to medicines but to other forms of support is vital, because people who will lose strength and balance and then have trips or falls will have more fear of having trips or falls and become more sedentary in their lifestyle. They need to have confidence that they can live independently and well in their own homes and in society. Having access to podiatry, physiotherapy and lots of other things will help them to live better lives. As we grow older, we all want not just to be medicated but to have good lives and to be active for as long as possible.

Claire Fernie: There are pockets of good ideas here and there. For instance, in Fife, we have started going into care homes with the GP and pharmacist to look at the residents' medications. That saves on waste, but the deprescribing and consideration of what a patient is on can also make a huge difference to their safety and wellbeing, their frailty and their ability to be better aware of what is going on around them, and improve their general quality of life.

We are starting to do some of those things, and broadening out the roles of non-clinicians—pharmacists, district nurses and the like—should make a big difference, but it is still early days.

David Torrance (Kirkcaldy) (SNP): My question is on waste of medication by patients. Do you have any insight into why patients stockpile medicines?

Claire Fernie: One reason is fear. People who have been told that they need a medication, particularly for the long term, who hear about medicine shortages in the current political situation, might be concerned that they will not be able to get hold of their medication and might therefore over-order.

Some stockpiling will be due to repeat prescriptions. That is particularly the case for patients who are on multiple medicines who are not confident about what each of their medicines is for, so they order repeats of everything because they are not sure whether they will need to re-order only the ones that they actually take all of.

We know that, for all sorts of reasons, patients order medicines that they do not take. If something changes, they might need to start taking a medicine again, so they reorder it. There are as many reasons for patients over-ordering as there are patients.

Adam Stachura: I would echo what Claire Fernie said about fear of not getting a prescription or of letting a repeat prescription slip. It is now less likely that people can phone their GP surgery, so they have to repeat their medication orders online, and they might have a combination of medications. In asthma medications, for example, one is a control or preventer and one is a reliever. Patients probably use their preventer, until it is finished, while the reliever does not get used up. The medications are ordered in a pack, so patients probably fear not having one and gain comfort from having the other.

People get into a routine. For people living with several conditions for 10 years, for example, it is common for them to put in their repeat prescription and get all their medications. I have spoken to health professionals who have been in people's homes and have opened up cupboards to find boxes and boxes of medication. The person might not be entirely sure why they have it all, but they have ordered it and have not needed it. Part of it is about the culture: through not having a medicines review, people are able to keep on repeating an order. Thankfully, repeating an order is a simple process, but people sometimes do not need medication, so they do not use it and it goes out of date.

There is also a fear that people who keep medication for many years might use medication that is out of date.

David Torrance: A number of patients do not turn up to collect medicine that they have ordered, so it just sits in the pharmacy. How can we improve that situation?

Adam Stachura: There are occasions when people are just physically unable to collect their medicine, or they might have gone into hospital and have had no one to pick it up for them, or they forget that the medicine is there. Boots and other pharmacies might consider charging for a home delivery service, but people might simply be unable to collect their medicine. That is one example—I do not know what proportion of the problem it is or what impact it has. Certainly, it would be a step forward if we were to make it easier for people to access their medication when their prescription has been filled by a pharmacy.

Claire Fernie: We do not have a culture in which community pharmacists, for example, are told when people go into hospital. As patients, we tend to expect everybody who is involved in our healthcare to know what is going on, but such communication does not necessarily happen, which means that things such as multi-compartment compliance aids continue to be made up based on the patient's existing medication routine, which might be changed while the patient is in hospital. That is a safety issue, as well as a supply issue.

David Torrance: How do people dispose of their medicines, and what level of awareness is there of return-to-pharmacy schemes? How could awareness be improved?

Claire Fernie: We are doing more and more work to make people aware of the need to return their unused medication to pharmacies. Awareness is definitely improving, but I cannot give you any numbers on that.

Over the past few years in Fife, we have been putting posters in pharmacies and on the back of buses, and we have been putting leaflets in patients' prescription bags reminding them not to order repeats if they do not know whether they will need them.

We have a new leaflet coming out fairly soon, one of the points of which is to remind people to check their bags before they leave the pharmacy. If someone has been prescribed medicine that they do not want or need, it becomes waste as soon as it goes out the pharmacy door. The majority of patients are not aware of that. We are making moves to get that information into the public domain through leaflets and poster campaigns in hospitals and GP surgeries, but we are not there yet.

David Torrance: How successful has that been in raising awareness?

Claire Fernie: We have reduced the number of tonnes of waste, but I am afraid that the waste is still measured in tonnes. We do not have an associated cost for that because we do not examine the drugs that are returned or their cost. It is estimated that we have reduced the amount by about 5 per cent over the past year, but it is a slow process.

The Convener: That is very interesting. If you could provide firmer figures when you get back to base, that would be very helpful to the committee.

Miles Briggs (Lothian) (Con): Good morning. My question follows on from David Torrance's question. In our inquiry, we have been pushing to find out about real-world experience and how we can improve for the patient the interface between primary and secondary care and make community pharmacy an important part of that.

We have heard about the poster campaign. From your experience, what could that interface look like? From conversations that I have had, I know that if someone goes to their pharmacist to ask questions—especially if they have been given advice by their GP—that is where they will get the information. When it comes to a patient's real-world experience, what could that interface look like, bearing in mind some of the evidence that we have received on the situation in care homes, for example?

Adam Stachura: Those are good questions. A lot of information is only available online. There might be plentiful information that everyone in this room could access and talk to their pharmacist about, but many people do not know how to do that. They will never go on Twitter to see the relevant advertising campaign and they will never interact with an NHS website.

Poster campaigns are good, but they can often include so much noise and clutter that the approach does not work for people who have visual impairments, for example. There are a number of challenges.

It comes back to the amount of time that medical professionals—pharmacists, doctors and practice nurses—have for talking to patients and telling them about their options. That might require a space in the pharmacy, away from the queue, where people could discuss their medication without everyone else listening in to what their ails are. I am not saying that that does not happen, but the picture is not consistent, because people are pretty busy. There is a lot of demand on services; it all comes down to having the time, the people and the money to offer such provision. That is a real-world barrier to people being empowered to interact with services.

Miles Briggs: Is the main block lack of availability of patient records, which prevents the professional—whoever that is—from being able to add value when they come into contact with a person?

Adam Stachura: I wonder why, when a person is prescribed medication in hospital, that information does not follow them to their GP, despite their having been asked in the hospital who their GP is. Many people would assume that that happens. Why else would they be being asked who their GP is? Why would their record not be passed on? The history of the various systems tells us that there will be huge difficulties in matching them up. If the person then goes to the GP for a different problem, the GP might not know what they have been prescribed. The person might not see the same GP twice in the same year, or might go to different GPs for different problems, which represents a big challenge.

We need to consider how a pharmacist would be able to access people’s medical records. A pharmacist would be able to talk about the medications that have been prescribed, and to go into more depth on how they interact with other medications or with the person’s body, depending on the person’s condition. I do not know how that would work without the pharmacist being able to find out what medication a person was on for other conditions, or what medical conditions they had suffered from previously. There is a big challenge in getting people in hospital, GP and pharmacy settings to talk to one another so that the professional who is at the critical intervention point has a loose idea of the person’s medical history and can make a good and informed assessment of what they require. After all, we trust the professionals to know about such things, so people are concerned that they are not able to access information because it does not follow the person.

10:15

Claire Fernie: People are, quite rightly, concerned about preserving patient confidentiality and patient data in those systems. There are barriers to making systems communicate that are to do with ensuring appropriate data sharing. However, if you speak to people with a lot of healthcare contacts or long-term conditions, you will hear that they are fed up with having repeatedly to explain their situation to every person every time because their record does not follow them. That is a huge barrier to safe treatment, let alone to comprehensive treatment.

Miles Briggs: We have heard that throughout the inquiry.

Finally, I have a question that is based on what has been said to the committee about falls strategies. The committee has heard that people being taken off meds can reduce the number of potential falls. Have you seen good examples of that holistic approach being put in place, whether for people who are still being cared for at home or for people in care homes?

Claire Fernie: Sadly, I cannot give you any examples, but I can say that such strategies are being put in place. We have not started gathering data yet, partly because it is early days, but there seems to be an improvement in terms of GPs and pharmacists considering the medications that patients are on. There are also hospital falls strategies that are focused on medication, too.

The Convener: Claire Fernie said that, from the patient’s point of view it would be good if their records were shared to facilitate treatment. In one word, does Adam Stachura agree with that patient perspective?

Adam Stachura: Yes.

Brian Whittle: I am going to labour this point, because I think that it is one of the most important things that has come out of the evidence. It seems to be a thread running through it. We have heard a lot in evidence that collection of data in secondary care, especially through hospital electronic prescribing and medicines administration—HEPMA—is becoming much better. We have heard that there is also collection of data in primary care, so a certain amount of data sits there, but the systems are not connected. We have also heard about the potential for pharmacists to improve the situation through having access to that data.

Claire Fernie has said that patients are fed up with explaining their situation all the time. There are general data protection regulation issues to consider. My question, which I have asked many times, is about ownership of data. Should the patient, at the very least partially, own their own data? That would get by the GDPR issues.

Claire Fernie: As a person with long-term conditions who is ultimately the authority on my health, I argue that the data should be mine. Although I have been saying that people with long-term conditions do not want to have to repeat themselves, there is also the possibility that people—for example, in very small communities—would not want to share their information with the pharmacist because the pharmacist is also their neighbour two doors down.

Confidentiality is not just about data management; it is also about confidence in who holds the data and whom they might share it with. I do not know what the solution is. I would like to see a national campaign through which everybody is made aware of all the health professionals who could hold their data, and people could then choose to opt out of data sharing.

Brian Whittle: Or opt in.

Claire Fernie: Yes. However, in a world in which we hear about data hacks every day of the year, a serious discussion needs to be had about patient data—who should have it and who would benefit, as well as when sharing it would be harmful.

David Stewart (Highlands and Islands) (Lab): What assessment has the panel made of the effectiveness of pharmacy first and the extension of its eligibility?

Adam Stachura: The answer to that will come to me, as I scrabble for bits of paper.

David Stewart: Perhaps I could be helpful and say that pharmacy first has just had a makeover. It was previously the minor ailment scheme.

Adam Stachura: It has been called that name, and pharmacy first, and something else in the past. A lot of people will not know that pharmacy first is available to them. It does a good and important job, particularly for the people who need such services. For us, older people are one of the big groups that could benefit tremendously from the scheme. The challenge lies in communicating that the service is available, where it is available, how it can be accessed and whether it is a digital-by-default example, which will work for many people. I do not think that it is embedded enough across the country that that brilliant service exists, and that people can go in and get medications for their conditions without having to pay for them.

One challenge is that the service is not available to residents of care homes. A pharmacist might be able to do the minor ailment part but a GP would be required to prescribe even the most basic things. There are lots of positive things about pharmacy first, but there is room for improvement.

David Stewart: I think that you have predicted my follow-up question. My sense is that awareness among patients of pharmacy first is extremely and painfully low. The panel's reaction to my first question sums it up, because awareness among the panel is perhaps not terribly high. That is not being unfair to the panel. Generally, the scheme is excellent, but I was always concerned that the old minor ailment scheme was not at all well known and that eligibility to it was more restricted. Eligibility is now effectively universal. Can you confirm that care homes are definitely excluded from pharmacy first? My understanding was that every NHS patient was eligible, but there might be some client groups that are restricted.

Adam Stachura: I will try to confirm definitively in writing, but my understanding is that it is not available in care homes.

David Stewart: Okay. As you will recall, the previous scheme, which was excellent, required patients to register with a pharmacist. Will the new scheme still require some form of registration? I assume that that would be necessary for accounting purposes.

How can we ensure that patients know about this excellent scheme? There is no point in having a fantastic minor ailment scheme, in its new marketing-man guise as pharmacy first, when patients do not know about it.

Adam Stachura: I think that it just boils down to a simple advertising campaign at all the touch points that people use. It is about ensuring that the scheme is not just stuck away on a website somewhere. I do not mean that in a Luddite-type way. The scheme is open to huge numbers of people, but if we look at the groups that will benefit most from it, there are people who might be able to use it instead of going to a GP, accident and emergency or a minor injuries department. We talked about leaflets and pharmacy bags. There could be information sessions in pharmacies, and bags could say, "Do you know that we offer this scheme?" Pharmacies could talk through the scheme with people, instead of saying, "Here's some information. Go away and read it", to which people will say, "I'm pretty busy and I've forgotten it—I've left it somewhere." More time and attention are needed so that people understand how the scheme could benefit them. It is such a great scheme that it could lead to a reduction in people using the wrong health intervention point for their condition.

David Stewart: It seems to be a really good fit with the reorganisation of primary care, does it not? We would have a different system in which someone would see the most appropriate health professional and not necessarily a GP. Also, by using a scheme that enables people to register and have a much more appropriate level of intervention, we would effectively redynamise the local pharmacy.

Adam Stachura: I agree. Instead of waiting weeks to see a GP, people could have quicker access to medications or whatever kind of healthcare they need. I will not go into too many details, but it took me four weeks to see a GP in the centre of Edinburgh. By then, the appointment was no longer necessary. For people who could go somewhere else for something else, the scheme would have worked.

There can be long waits for people to see a GP. There is a report in *The Courier* today of a GP practice in Arbroath that is closing and how 6,000 patients will be affected. People might have more trouble with going somewhere else. However, pharmacies are an important part of the system, largely because they are convenient for people to get to because they are at the heart of communities.

Claire Fernie: To add to what Adam Stachura said about publicity, we might need not to restrict publicity to medical environments. Perhaps information should be sent out to schools, community councils and so on. We should make sure that there is full engagement with the community and the general public, rather than engagement just with the health professionals who know about the scheme.

I can give you an example of the success of the previous scheme. We tried to do a study at the University of St Andrews school of medicine on urinary tract infections. Our researcher went to GPs to ask for prospective patients, and was told that GPs do not actually see those patients; the researcher had to go to the pharmacy to speak to the appropriate potential patients. In the end, the researcher ended up in the middle ground with patients who had received out-of-hours care, because that system uses the referral system. The scheme had been successful enough that the GPs were no longer seeing that patient group.

The Convener: That is exactly what the minor ailment scheme was intended to achieve.

George Adam: My wife Stacey has multiple sclerosis and she uses the minor ailment scheme. I find it difficult that people do not know about the scheme and use it as often as they should; maybe that is because Stacey is never out of the pharmacy, right enough. The people there know her by name, so when she phones the pharmacy, they say, “Is that you, Stace?”

The idea is that people do not use the GP or accident and emergency. They are not turning up there and things are being moved away from them. Stacey got a small burn because of her MS-related mobility issues, and the burn had to be treated. The pharmacy was able to put on a dressing and deal with it for her. Because of her low immune system, she had a bad cough and the pharmacy was able to deal with that, too. Otherwise, she would have had to go to the GP and she might have been in the same situation that Adam Stachura said he was in in Edinburgh.

It is not rocket science. It just makes sense that people, particularly those who have long-term conditions, should use that scheme.

The Convener: Does anyone want to agree with that?

George Adam: My main point is that I cannot understand why more people have not taken up the scheme. Do people think that they need to speak to a GP or a professional? Do they not see the pharmacist as being on the same level as the GP?

Claire Fernie: It might be that, if it is something simple and they can get something over the counter at the supermarket, they will just take the medication, but if they cannot do that, they need to see a health professional, so they go to their GP. People are not seeing that their condition might not need that level of consideration.

The Convener: From the patient’s point of view, we are agreed that the minor ailment scheme works. However, there is not sufficient awareness of the scheme, so is there anything that we can do to increase awareness as the scheme prepares for relaunch?

Adam Stachura: It is about doing everything that we can to advertise it broadly. George Adam gave great examples of how the minor ailment scheme has worked in his life, and perhaps people who have long-term conditions are more au fait with what is available to them and all the services that they can interact with.

There is a long-term historical issue. As soon as the NHS was born, people were told that they could access it for free and that they could go and see their GP and so on. It has been ingrained in people’s minds that they should go and see their GP for these things, so it will take time and a consistent amount of advertising over a long period of time to embed the idea of the minor ailment scheme. Using people’s experiences of what has worked for them as opposed to going to the GP is a really good way to tell the story. It is better than just using a prescriptive list of things that the scheme can do. We need to think about how to use people to show how the scheme has helped them and given them quicker access to something that improved the quality of their life.

The minor ailment scheme clearly works. I agree that it is brilliant and will get people away from going to a place that is wrong for them.

10:30

Emma Harper: I am interested in issues to do with online pharmacies. At a previous evidence session, the pharmacy representatives did not seem too worried about online pharmacies affecting community pharmacies, because community pharmacies provide a different service, but if someone orders their meds online, there is no human to human—or healthcare professional to patient—contact. I am looking at a web page where metformin and inhalers can be obtained. We want to get folk off their type 2 diabetes meds through the use of social prescribing, but if people simply order repeat prescriptions online, how can we review them? Do you have any concerns about online pharmacies?

The Convener: Adam Stachura?

Adam Stachura: I was hoping for an expert to go first, whom I could agree with. [*Laughter*.]

There will be some things that it will be really convenient for some people to order from online pharmacies, such as inhalers. People who routinely need inhalers will get an asthma check-up or some kind of intervention from the GP or practice nurse on a fairly regular basis—I think that that happens every year. Without such a check-up, the GP will stop prescribing the relevant medication. In some cases, people might find that online pharmacies make it much easier for them to get the medication that they need. That might cut down on some waste, because there will not be medication just sitting at a pharmacy that people have forgotten about. I am talking about routine things that it is convenient to order online, such as contact lenses.

However, I come back to the point of a medicine review, which is to ensure that a patient is on the right medication, however they get access to it. They should get a check-up from a GP or someone in the GP’s surgery that involves asking them how the medications that they are on are working for them and what side-effects they are having. That is an important stage before people get to the point of accessing the medication that they need. If people knew more about how beneficial it can be to have discussions with a pharmacist, they might be driven to go and have such face-to-face discussions. That face-to-face contact is important, because it makes people feel empowered to ask questions.

I am sure that there will be things that it will be convenient for people to order from online pharmacies, but if people knew that they could do more in person at a pharmacy, they might use that service more effectively.

Claire Fernie: I agree with Adam Stachura. The issue is very much about patient convenience. I share Adam Stachura’s concern that the conversation about whether the medication that someone is on is suitable might not take place, or might not be as comprehensive as it should be.

We have talked about data sharing. I do not know what systems are in place to make sure that the medication that I obtained in that way would form part of my patient record so that it would be possible to find out how it related to anything else that I was taking or any other condition that I might have. I have reservations about the use of online pharmacies, but I know that it works for some people.

Emma Harper: Online pharmacies are supposed to be more convenient. What are the benefits of engagement with a community pharmacy? One thing that comes to mind is that, at a community pharmacy, it is possible to check people’s inhaler technique or whether they have a spacer for their inhaler. People using their inhaler meds appropriately can prevent them from being admitted to hospital. Community pharmacy is beneficial in enabling checks to be carried out on whether people are taking their meds properly.

Claire Fernie: Yes, a community pharmacy is the best place to have that education. It is also the place to build up a relationship with the patient, so that the patient is more likely to say, “I really don’t like taking that tablet, because I find it difficult to swallow.” They might not be willing to have that conversation with their GP, because they think that their GP knows best and they do not want to contradict them. In some cases, the patient will be very aware that there is a shortage of appointments and will not want to bother the doctor.

Therefore, I agree with you. Community pharmacy would be a great place to build up those relationships, and I think that we should be promoting it.

Adam Stachura: I agree entirely.

The Convener: I thank both our witnesses for their evidence, which has been extremely helpful. I mentioned to Claire Fernie that it would be good to get more detailed feedback on the difference that the project that she mentioned has made, but if there are other matters that we want to follow up on, we will write to you.

10:35

Meeting suspended.

10:39

On resuming—

The Convener: I welcome our next panel for our inquiry into medicines supply and demand.

The witnesses will also answer questions on consumption and waste.

I am delighted to welcome Dr David Shackles, executive officer for interface and out of hours at the Royal College of General Practitioners Scotland; Adam Osprey, policy and development pharmacist at Community Pharmacy Scotland; Jonathan Burton, chair of the Scottish pharmacy board of the Royal Pharmaceutical Society in Scotland; Dr Sheuli Porkess, executive director of research, medical and innovation at the Association of the British Pharmaceutical Industry; and Graeme Bryson, director of pharmacy at NHS Dumfries and Galloway.

I know that a number of the witnesses were present during our earlier evidence session with patient representatives and will know the areas in which we have an interest as part of the inquiry.

I will start by asking about patient adherence to prescriptions. In the witnesses' view, how aware are prescribers of the adherence or otherwise of patients to prescriptions?

Dr David Shackles (Royal College of General Practitioners): I will go first. We are all aware of difficulties with compliance—perhaps "concordance" is a better term to use for variability in how patients take their medications. As prescribers, it is beholden on GPs to have conversations with patients about how they take their medications and which medications they take.

Technology can enable us to have those discussions. We can use the repeat prescribing record to look back to see how well patients collect their medications, and to have conversations with our colleagues in community pharmacy, who alert us if medications are not being collected. There is a multidisciplinary team effort in that discussion. For example, community nursing colleagues might report back that there is a stockpile of medications in a patient's home, which would alert us to the fact that they were not taking their medications as effectively as we might think.

The Convener: From a GP's perspective, do you normally expect to be told if another healthcare professional was aware of stockpiling or of non-concordance, to use your term, with prescriptions?

Dr Shackles: Yes, I think that we would be informed of that.

The Convener: That is standard.

Dr Shackles: We would expect it—particularly now, given some of the newer initiatives in which pharmacy technicians go out and visit elderly patients at home and look for that sort of issue.

Jonathan Burton (Royal Pharmaceutical Society): I really liked what was said by Claire Ferrie, who was on the previous panel—it was along the lines of there being as many issues are there are patients. Medicines are complex, but human beings are even more complex, and there are a multitude of reasons why medicines are not taken, or are not taken appropriately.

I agree that we need to take a multidisciplinary approach to the issue. Community pharmacy has a role, in that we are good at spotting and raising issues. We probably need to be better connected, information technology-wise, to make sure that we share issues in an understandable way so that our GP colleagues can deal with them effectively. We now have another layer of pharmaceutical input, with pharmacists working in GP practices.

As we say in the RPS submission, the time to care element is so important. The committee heard from patient representatives about the value of building rapport and having trust between practitioner, pharmacist and patient. It is only when you start to develop that trust that people will open up a bit more about the genuine reasons why they are not taking medicines or about their worries and concerns. We also need to take responsibility as professionals to be as proactive as possible in raising issues when we think that things are not quite right.

Dr Sheuli Porkess (Association of the British Pharmaceutical Industry): Thank you for the opportunity to be a part of the evidence session.

As an industry, we are committed to ensuring that patients are prescribed the right medicine at the right time, but we realise that it does not stop there. The question of adherence is absolutely the right one to ask.

We know that medicines do not work in patients who do not take them, but how we empower and educate patients to adhere to their treatment is really important, as we heard from the previous panel. Our view is that the issue should be treated as a public health priority. How do we understand adherence, and how do we support patients to be able to make the right choices in the first place and then to take their medicines? We have heard a couple of themes already about using IT infrastructure and linking care records to make what is going on visible to multiple care professionals.

10:45

Could we take that further and interlink real-world data to help us to understand what is happening? Individual manufacturers have initiatives to support patients with information and to provide support for individual medicines, but the ABPI would be really happy to be part of conversations about what more we could do and whether there are the opportunities to help further.

The Convener: That is interesting. You talk about individual manufacturers taking initiatives to provide information. Are there other things that can be done in the production and development of medicines that could make patient adherence to medication easier to deliver?

Dr Porkess: Absolutely. Feedback is critical here: for us, it is really important to understand why patients do not take their medicines. If a patient does not take their medicine because of side effects, we need to know about that. Clearly, the patient's doctor needs to know so that they can work with them to change the prescription or look at another treatment. The companies also need to know what is happening, so that we can look at whether we need to change the information that we give about the medicine, or—as you mentioned—consider different development options in the future.

The Convener: Are there such opportunities in developing medicines?

Dr Porkess: Yes. It could involve exchanging a tablet that is taken three times a day for one that is taken once a day, exchanging an injection for a tablet—or vice versa, depending on the clinical situation—or exchanging tablets for liquid formulations. There are lots of different options, but it is really important to understand the underlying reasons why patients take or do not take medicines.

Dr Shackles: I will come back on some of the points that have been made. In any health relationship, it is important that people trust the health professional that they see. The RCGP always promotes continuity of care, which is important in relationship-based care but which has become more difficult to provide given the reduced numbers of GPs, the increased demand and the decrease in the amount of time that GPs can spend with their patients. Those are issues in urban areas—we hear that people have problems seeing their GP in Arbroath and in central Edinburgh—and in rural areas, in which there might be fewer practitioners or a need to import locums to work in practices. All those issues result in a fragmentation of care, a lack of continuity and, potentially, a breakdown in relationships and a reduction in trust in the profession. Therefore, people are perhaps less likely to take medication appropriately or accept advice.

The issue is not new: 20 years ago, John Howie, a professor in Edinburgh, looked at patient enablement and how doctors could encourage their patients to manage their conditions, look after themselves and take the right treatments. Given the time pressures, patient enablement is difficult to do, but it is something that we need to encourage our trainees to manage. However, the pressure on training means that elements such as patient enablement or motivational interviewing to help our patients are being squeezed out of already busy training schedules.

Emma Harper: Good morning. I will pick up on what Dr Shackles said about community nurses checking whether patients are stockpiling meds. Is that happening? Do community nurses think to check whether there is stockpiling when they visit patients at home?

Dr Shackles: Yes—certainly in my experience. Such discussions are often had when there are good links between the general practitioner and the community nurses. There are often good links when the nurses are embedded in the practice and when there is ease of discussion and good multidisciplinary meetings and working. Our community nursing colleagues are much more attuned to the needs of the elderly in particular, in relation to medication. They often provide a valuable link with those providing social care as well, who will feed back if they have concerns about how their clients are taking their medications.

Emma Harper: I have another wee question about smart inhalers, which Miles Briggs and I have previously raised. The technology connects the inhaler to an app on the patient's phone to remind them to take their inhaler, which is good for compliance. What about people who have three blue inhalers: one next to their bed, one in the doocot of their car and another in their handbag? If they have three blue inhalers handy, in case they need them, is that a non-compliance issue?

Dr Shackles: I do not see that as a non-compliance issue. People do that because they are anxious about having the right medication at the right time. We often advise patients to keep medication handy—just as we prescribe medication for young people to have available to them at school, if it is required. However, in care homes, there is sometimes a difficulty, because if we give everyone an extra supply of medication there will be lots of it available. In certain situations, it would be more sensible to have central stocking. Clearly, there are issues to be overcome about how that can be controlled to ensure that the right patient gets the right medication, and to avoid wastage if medication goes out of date or is not used.

We have the same problem with just-in-case medications, particularly when they are being used in care homes. Several patients may have been prescribed the same medications—they are often controlled drugs. Those medications are available but they are either not used or only partly used and then they go out of date and are jettisoned.

We are all aware of that issue, and we seek to try to remedy it, in discussion with pharmacy colleagues.

David Torrance: Evidence that was submitted to the committee suggests that better packaging and product design could reduce waste. To what extent do pharmaceutical companies try to minimise the wastage of medicines in the design of their products?

Dr Porkess: It is worth thinking about packaging in two ways. One of its roles is to ensure that it is clear what a medicine is, and to give some information on it. That is done using a leaflet inside the packaging. Its other role is to protect the medicine and to ensure that it is of the right quality, so that when a patient takes it they know that it is a quality product that has been kept in the right conditions. Manufacturers are always thinking about those two things in relation to packaging: how to ensure that the medicine remains the right quality, and how the patient can be assured that, when they take the medicine, it is what it says it is on the packet.

The packaging of medicines is a highly regulated process, so everything that we do has to be done in conjunction with the regulators. A number of quality steps are taken along the way to ensure that everything is as it should be.

Manufacturers are looking at ways to make that easier, and that comes back to my earlier point about having feedback. For example, if a manufacturer hears that patients who take a medicine find the bottle hard to open, it will try to find alternatives that still meet the right quality standards and can keep the medicine safe. It goes back to understanding the issues behind why patients are not taking their medicines and how manufacturers get feedback from healthcare professionals on how medication and its packaging work in a real-life setting.

David Torrance: Is there any incentive for pharmaceutical companies to reduce waste? If packaging was designed better and it was a lot safer, could it be returned and reused?

Dr Porkess: I will answer that in two ways. I will talk about pharmaceutical companies and wastage, and then I will talk about reuse of medicines.

We are a long-term-research based industry that relies on results to show that we treat unmet medical needs. We know that no medicine works if it is not taken, so medicines being prescribed and not used is not in the companies' interests.

If medicines are being prescribed but are not being taken, we need to know what is happening. If medicines are not being taken as a result of side effects, we need to know about that so that we can learn from it. If medicines are not being taken for another reason—for example, the packaging is too difficult—again, we need to know about that. At the end of the day, if patients do not take a medicine, they will not get any benefit and then doctors will not prescribe that medicine again. It is really important that we learn from people's experiences so that we can make sure that the right patients get the right medicine for them. It is not in the interests of the industry, the patients or the NHS to have wastage. We want to be part of looking at solutions.

On reusing medicines, we know that the storage conditions for medicines are controlled up to the point at which they leave the pharmacy—that point was made earlier. While a medicine is being manufactured, stored in a warehouse and then stored at a pharmacy, we can guarantee that it is being stored in the right conditions. If it is a medicine that needs to be stored in a fridge at a certain temperature, we know that it has been stored in a fridge, that the fridge has been at the right temperature and that the medicine has been kept in the right conditions.

As soon as the medicine leaves the pharmacy, we do not have that control anymore. It might still have been stored in a fridge but was the fridge turned on? Was it kept at the right temperature? Was the door opened and closed a lot so that the temperature of the fridge did not stay stable? We also know that it is difficult to see just from looking at a medicine packet whether that packet is intact; you cannot tell just by looking at something whether it has been stored correctly.

It is difficult to reuse medicines once they have left those controlled conditions because we do not know where they have been and we cannot assure their quality for whichever patient takes them next.

The Convener: Only a relatively small number of medicines require refrigeration, so could more be done with packaging to ensure secure storage? Given the levels of waste that you know about, could more be done in relation to how medicines are packaged that would enable more of those medicines to be reused? In the majority of cases, they do not need to be in a fridge; they simply need to be safely stored.

Dr Porkess: All medicines have storage requirements, whether that involves being in a fridge or not. Even packets that can be put on shelves in cupboards have storage requirements, whether in relation to temperature or humidity. There are a number of different requirements. As soon as medicines leave the controlled conditions of the pharmacy, we do not know where they are being kept. They could be in a cupboard next to a cooker where the temperature goes above 25°C because the cooker is on, or they could be in a cupboard in a basement where it is really cold and the temperature goes below the recommended storage temperature. We just do not know—and we do not have the records.

The storage requirements are all set in conjunction with the regulators. The regulators look at the evidence to see the storage requirements that will ensure that the medicine remains the right quality and then they agree those requirements with the manufacturer.

It comes back to how we prevent wastage in the first place and how we get information so that we know what is causing wastage. What are the contributing factors? Are there particular areas it would be best to focus our efforts on? Rather than just trying to solve it all, where could we start?

Brian Whittle: I completely understand that once a medicine leaves the pharmacy, you do not know what conditions it will be kept in. In terms of wastage, can we look at the volume of a prescription? With just about every prescription that I and my children have ever had, we have not used all of it before there is no more need for that medicine. In relation to stockpiling, is there somewhere in the process at which we can look at the volume of the medication that is prescribed?

Dr Porkess: We would absolutely support what the people on the first panel said about the importance of having, in the first instance, a good conversation between the healthcare professional and the patient to discuss what would be the right medicine, how long to take the medicine for, and how often to take it.

Other colleagues could probably tell you about the volume that is prescribed and dispensed better than I could.

We absolutely support regular reviews, so that when a prescription is written and the medicine is dispensed but it turns out that the medicine is not right for the patient, the patient has the option to go back for that discussion.

11:00

Miles Briggs: We have had quite an in-depth discussion about waste, but I want to move the discussion towards the environmental impact of inappropriate disposal of medicines. Do we have evidence on that? A submission that we received from the one health breakthrough partnership suggests that about a fifth of the NHS's carbon emissions across the United Kingdom were from pharmaceutical products. Do you have examples of action that is being taken to limit the carbon footprint of the NHS and its impact on the environment?

Jonathan Burton: I can say something not so much about the carbon footprint, but about the unintended consequences of inappropriate medicines waste disposal—that is, medicines ending up in landfill or being flushed down the toilet. Obviously, there is a message there about communication of issues to the public. Inevitably, households generate a certain amount of medicines waste. It is important that people realise that, in the UK, it is easy to take unused medicines back to a pharmacy, so there is no need for them to end up in household waste. Rather than it being a message that only health professionals put across, that needs to be part of the wider environmental waste-disposal message. We all have several recycling bins outside our houses. I am not suggesting that we should all have a medicines bin as well, but medicines disposal has to be part of the message.

When I was doing my homework on medicines waste, I noticed that there are quite a few scientific studies about, for example, the impact on water and the environment downstream from landfill sites. If you trawl through the literature, you can find examples. Furthermore, a few years ago, one of the big US environmental agencies did a wide-ranging review of the impact of disposal of medicines, including hormone medicines and veterinary medicines, on the environment around landfill sites, refuse plants and so on.

There is evidence out there—there is definitely an environmental side to the issue, which we are possibly underplaying to the public. I admit that that is not something that I have given an awful lot of thought to, but medicines waste certainly has an environmental impact, and the public might respond positively if we make that part of our message. I know that patients can feel guilty when they bring back medicines to a pharmacy; they might have anxieties around their doctor, pharmacist or another health professional knowing that they have not taken their medicines, even though there might be perfectly sensible reasons for their not having done so. We need to have more conversations with patients about that.

It is fair to say that the environmental impact is being studied.

Dr Porkess: NHS Wales has a “Spring clean you medicine cupboard” campaign, which might be worth looking at to see what can be learned from it.

Miles Briggs: What are the requirements on manufacturers with regard to packaging, leaflets and so on? Recently, I had a conversation with a company about disposable contact lenses. Many people flush them down the toilet or wash them down the sink because they have not had a conversation about that and do not realise where the lenses end up. They can end up being eaten by fish. Is there a need for brief conversations with people about that, including asking them to dispose responsibly of their lenses?

Dr Porkess: I have mentioned that companies must adhere to international packaging standards. In addition, the industry has been working to remove unnecessary packaging from products.

I am not aware of how conversations with patients about how to dispose of medicines when they have finished with them happens in practice. I do not know whether colleagues around the table can talk about that.

Adam Osprey (Community Pharmacy Scotland): It is very much down to the professional. In its evidence sessions, the committee is hearing that it all comes down to good-quality conversations with patients. If there is a hint that medicine will not be used, the patient should absolutely be encouraged to bring it back to the pharmacy. That is happening, as Jonathan Burton said. That message is going out.

Maybe Miles Briggs's question is about whether there should be space on packaging to set out what one should do with the product if they do not use it. The regulatory requirements for what needs to be on packaging are already high. Also, the industry is trying to reduce the size of the packaging, so it is not clear where such a message would go and where it would grab attention. Therefore, for me, the matter comes back to the conversation between the professional and the patient.

Dr Shackles: Such conversations are becoming more commonplace. They started off with the more obvious things—for example, about our self-injecting diabetic patients needing to return sharps and other disposable materials to their pharmacist. With the advent of other injectable medications, including Fragmin, we are having more conversations. Our patients who take regular inhalers like to return those. There are various schemes to allow that to happen, which is quite appropriate.

I agree that the approach needs to be rolled out to cover other unused medications, so that we deal with medications not only because they might be reused—which is not necessarily appropriate—but because of the environmental impact. Patients are becoming much more receptive to that. However, our profession needs to continue to have conversations with patients, including when medications are dispensed to say that medications can be returned.

Dr Porkess: Sustainability is a key workstream for the ABPI this year, so we would be happy to continue to have those conversations, as they develop.

The Convener: That is helpful. I acknowledge Adam Osprey's point that there is no room on packaging to put everything. Would the costs of the medicines being on packaging encourage patients to return medicines?

Adam Osprey: I have a very visceral personal reaction to that. When considering whether to display the price, you have to think about a number of things. What if the price of the medicine is less than expected? What behaviour would that drive? You will have heard in other evidence sessions that generic prescribing makes up the bulk of prescribing. Therefore, the cost per packet of some medicines is relatively low.

There is also an issue to do with stigmatisation and shame. How would displaying the price make patients feel? Based on my experience, I would bet that the people who would feel shame on seeing the price and who then do not take the medication would be exactly those who need it. The moment that somebody chose to save the NHS £5 by not taking medicine that would prevent their having a stroke in a number of years is the moment that the initiative would have failed.

I feel strongly that that is not the way to go. This is about taking preventative action, having a conversation and getting people to value medicines and not just to see the price, because the value and the price are two entirely different things.

The Convener: Okay; that is a fair point.

David Stewart: How can we better control medicines waste in hospital settings?

Graeme Bryson (NHS Dumfries and Galloway): As you have probably heard in previous sessions, the difference in a hospital setting is that we have a closed-loop supply system. We bring the medicines into the pharmacy, and they are then either issued to wards or given to patients on discharge. For medicines that are issued to wards, we have assurance that manufacturers' temperature and storage requirements are being adhered to. That gives us an opportunity to recycle in the system medicines that are not used. It is important to note that no system is waste free, as one of my colleagues said earlier in relation to just-in-case medicines. Hospitals have a list of what are known as rarely used medicines, which we are obliged to keep for particular clinical situations. If those situations do not arise, some of that stock of medication will, unfortunately, go out of date. However, it is a small amount.

Another hospital situation in which there might be waste is when an unusual medicine that is not routinely held in stock is prescribed for a patient on a particular clinical indication. That patient's clinical situation might change, which would require the medication to be stopped and there is low likelihood of its being needed it again. To mitigate that, we do not normally keep large supplies of such medication in the hospital.

As I say, no system is perfect, and there can, unfortunately, be incidents such as a fridge failure in either the pharmacy or a clinical ward, which might mean that we fall outwith the regulations for retaining medication for use by patients. In a hospital pharmacy department, we can run a pretty tight ship. Our biggest challenge is probably when medication leaves the pharmacy and is taken to a ward.

As you will appreciate, hospitals in NHS Scotland are running pretty hot at the moment, which means that there is a quick patient flow through departments. However much we try to put in place systems to ensure that a medicine that is issued to a patient in one setting follows the patient to the next setting, that is often not possible.

David Stewart: Are the targets for medicines waste in hospitals being met in your board and in other boards across Scotland?

Graeme Bryson: In my time in NHS Dumfries and Galloway, which has been relatively short, we have not had to contact the Scottish Government about any significant medication loss. That is set at the level of £50,000. Across Scotland, that is a recognised benchmark to ensure that there is minimum waste.

David Stewart: We have heard in previous evidence sessions that the key performance indicator, which is that no more than 0.4 per cent of medicines should be wasted, is being met. Can you confirm that?

Graeme Bryson: That is fair to say.

David Stewart: Can the panel provide examples of best practice, from Scotland or other countries, that we could use in our inquiry?

Jonathan Burton: Are You asking about what happens across the board now, outwith secondary care?

David Stewart: Yes.

Jonathan Burton: It is not an overstatement to say that pharmacy practice in Scotland is the envy of the other home countries. There are a number of reasons for that. In community practice, we have an evolutionary process that was formerly known as the chronic medications service and is now known as the medicines care and review service. There is an online system called the pharmacy care record that we populate with the work that we do in community pharmacy practice on speaking to patients about their new and on-going medicines.

The foundation of that system, which is fairly unique, is a basic “How are you getting on with things?” check that asks patients whether they know what they are taking their medicines for and whether they can take them properly. That has been embedded for a number of years; it is fair to say that we need to do more work on it to ensure that we are absolutely consistent and that patients get the help and support that they need with their medicines.

If we look at how our general practice workforce has fallen into place over the past couple of years and the impact that staff have made in many general practices, including those that were struggling from a manpower point of view, we can see some fantastic examples of how we have managed to keep medicine safety at the forefront of what we are doing.

11:15

Dr Porkess: There are other things to look out for on adherence. There is an NHS Wales public health campaign called “Your medicines your health”, the general message of which is, “Take your medicines if you can and tell us if you can’t.” That might be something to look out for.

Dr Shackles: I will go back to the point about medicines waste in hospitals. I have an interest in medicine at the interface between primary and secondary care, an area where waste can often occur. Sometimes, when our patients go into hospital on a certain medication regime, for understandable reasons certain medications might be withheld, perhaps because of renal problems or whatever. Those medications might be taken away from the patient to be restarted when the patient is discharged, but a new supply is required because the original supply has been taken away and lost within the hospital. That can create a considerable amount of waste. We need to have better discussions about that between primary and secondary care.

I certainly agree with Jonathan Burton that one of the most influential and important things that has happened in the past few years is the embedding of pharmacists within general practice. Medicines reconciliation—looking at what medications patients are on when they are discharged from hospital or even before they go into hospital—is critical and useful.

Another important thing to emphasise is communication with the patient. Hospitals provide the patient and/or the carer with a list of the medication that the patient is taking on discharge and the reason why they are taking it, and that is very useful. The discharge letter is often written to the patient to inform them of what went on in hospital so that they can better understand what medication they were on. Such initiatives are to be commended. They are not universal, but they are becoming more common and are very much applauded by the Academy of Medical Royal Colleges and Faculties in Scotland.

The Convener: What needs to be done to make such initiatives more general?

Dr Shackles: In my health board, one of the brakes on that is the cost of communication and sending out additional letters. That can be a barrier, but when it is seen as good practice, clinicians like to use it. We should empower clinicians to use such initiatives and make them commonplace and best practice. The easiest thing to do is to celebrate it, because when we can see the benefits to the patient and to the system, more people will start to do it and the cost will be absorbed in the benefits or the reduction in waste.

The Convener: Emma Harper and Miles Briggs have brief supplementary questions.

Emma Harper: Graeme Bryson said that the level at which wasted meds had to be notified was £50,000. How does that compare with the total meds expenditure?

Graeme Bryson: That depends on the individual board. The way to consider the figure of £50,000 is as a trigger to advise that there has been a significant incident, rather than as a percentage of the overall spend on medicines in the acute sector.

Emma Harper: Elective patients are encouraged to bring their own meds into hospital. Is that monitored as a percentage? Are patients bringing their own meds into hospital so that we can use their meds that are already prescribed and not have to reissue them?

Graeme Bryson: I am not aware that we count in that particular way. It would be more an ad hoc consideration by an individual hospital that felt that the message was not coming out strongly enough and there might have to be a bit more of a conversation with patients either at pre-assessment or as part of the information that they are given before they come into hospital.

Miles Briggs: Through the work that I do in co-chairing the cross-party group on cancer, I know that cancer patients are now entitled to a patient treatment summary. What value does that add to any further conversations that take place? You have outlined the admin costs of delivering that for every single patient, but could the system be simplified to give every patient the information that they need before they leave hospital?

Brian Whittle and I recently visited Crosshouse hospital. The pharmacy that is embedded in the accident and emergency unit there offers a similar service. How do you see that idea developing across all patient groups?

Dr Shackles: There is considerable value in a patient treatment summary. Patients and their carers can read and absorb what has happened, which can enhance the conversation that they have with their GP or any other health professional, be that the district nurse at a home visit, a Macmillan Cancer Support nurse or a community pharmacist.

That is being mirrored in other areas, such as the house of care model for chronic disease management. Patients attend for their investigations, are sent a summary of the investigations and then go to the practice nurse and discuss the results. They can then discuss what is important to them and what issue they want to target. For example, for diabetic control, is it their HbA1c or their weight? Giving patients information before they have that shortish professional discussion allows them to work out what is important to them and how best to target it, and to make choices for themselves. That model is a very useful intervention.

Adam Osprey: My colleague Jonathan Burton mentioned earlier the evolution of the medicines care and review service in community pharmacy. Even in its current form, it is absolutely a goal of that service that, over time, patients across all patient groups are given a treatment summary, and that they are able to gain access to, or have print-outs of, any care issues that are identified, actioned and resolved. That is also shared at the end of treatment. The patient is, in essence, discharged into the care of the community pharmacist for whatever medication they are given as a long-term serial prescription. Information about what happened during the six months, or the year, that the prescription lasted is communicated back to the patient’s GP as well. The committee heard earlier about issues regarding sharing information, but this is one area where that is working well. Although there is a lot more to be done to make it more commonplace, that absolutely helps in keeping patients as active participants in their own care.

The Convener: We have heard that discharge from hospital can be delayed, in part, due to difficulty in getting the necessary medicines signed out in time for a patient to leave on the same day that they should. Can anything be done from a hospital pharmacy point of view to focus on and address that issue?

Graeme Bryson: I will not repeat anything that you have heard from previous committee meetings about that. I will, however, allude to a piece of work that my colleague Gail Caldwell from NHS Greater Glasgow and Clyde mentioned, about how, in the west of Scotland, we are looking at the possibility of alternative discharge medication supply routes. However, that requires significant scoping, and we would need to do additional work before we could make any sort of firm decision.

The Convener: I understand that point. Can you tell us what is being looked at as potentially offering an alternative supply route?

Graeme Bryson: I will give you an example of where we are in NHS Dumfries and Galloway, particularly out in the west of the region, in the Stranraer area, where we have a very strong community pharmacy network that is associated with and next to our Galloway community hospital. At the moment, we have a situation in which our community pharmacies provide the discharge medication—not on a 100 per cent basis, but where it is appropriate. Our next hope is to use our electronic immediate discharge letter to facilitate that. As I said, it is very preliminary and very much at the scoping stage.

The Convener: The committee will certainly find it interesting to hear more about that as it develops.

Brian Whittle: The committee has heard a lot about the deployment of the HEPMA system in secondary care and its potential to improve the supply and prescription of drugs in that setting. I know that it has been deployed in several boards, Dumfries and Galloway being one of them. You are back in the hot seat again, Mr Bryson. Will you give us a wee insight into how the HEPMA system is working in Dumfries and Galloway?

Graeme Bryson: It is worth saying that we were in the early implementer phase, along with a couple of other health boards. We have had HEPMA installed in NHS Dumfries and Galloway royal infirmary for between four and five years. It was installed a couple of years before we moved to the new build on the outskirts of Dumfries.

It is important for the committee to see HEPMA—the hospital electronic prescribing and medicines administration system—as a two-phase process. The first phase is around the move from the old traditional cardex model to an electronic cardex or record for medicines and prescribing. The second stage is about how we use that technology and the data that is generated from it to improve the safe and effective use of medicines in our hospitals.

Within NHS Dumfries and Galloway, we are at a stage where we feel that we have secured the changeover from the old to the new system. There was potential for interruption by our move to the new hospital, which is a hugely significant cultural issue that we have to see through, but we are now at the stage where we are opening the door to the benefits that we can get from looking at the data. I have spoken to medical, nursing and pharmacy colleagues who say that, from a medicines administration point of view, the advantage of HEPMA is that it provides a clear and legible record that reduces the risk of medication administration errors.

Interestingly, for nurses, the specificity of the system means that only the medicines that are able to be dispensed at that particular time are dispensed. Again, that further reduces the risk of administration errors. Nurses have also commented that one of the advantages of HEPMA is that they no longer have to root about for cardexes because they are able to work from laptops in patients’ rooms. We must not underestimate the positive effect of that. Colleagues talk about releasing time to care and there are wee marginal gains in terms of the minutes that are saved and that can be put back into patient care.

Our system requires prescribers to give a complete prescription record, right down to the nuances of formulation, dosage and frequency, which means that when a prescriber decides that a patient is to get a medicine, they are required to give 100 per cent of the detail. Often, in a busy environment, a small detail can be missing and as a result other members of the MDT, such as nursing or pharmacy staff, have to go back to that prescriber and ask for a wee bit of clarification. Because the default situation is that we have to provide all the information at the point of prescribing, we waste less of people’s time.

I alluded earlier to the Galloway community hospital. The HEPMA system has allowed us to introduce what we would call remote prescribing there. We use that within the renal dialysis team. Renal consultants in the Dumfries and Galloway royal infirmary are able to prescribe for patients who are being treated 75 miles away in Stranraer. That is a very effective use of the technology and it allows people to make effective use of their time.

From a pharmacy point of view, we have talked a lot about transcription errors and the ability to reduce the risk that those present.

We are at the stage where we are starting to look at the data that is generated from HEPMA. The best example that I can give the committee is the daily antimicrobial reports that we generate. That is done as part of the microbial team’s ward rounds with the orthopaedic and surgical teams to make sure that we are adhering to the good principles of antimicrobial stewardship, which is a high priority public health issue within the NHS in Scotland, as, I am sure, the committee is aware.

That has been our journey so far. I will wrap up by talking about where we see ourselves going next in our use of HEPMA.

Within the Galloway community hospital, we have recently introduced remote pharmaceutical care to supplement remote prescribing, which saves practitioners' time and makes the best use of our resources.

For a couple of years now, we have been routinely sending the electronic immediate discharge letter to community pharmacies for patients who have high pharmaceutical care needs. That relates in particular to the medication support services that we have to provide.

We have recently completed what we believe to be the first out-patient prescribing pilot in the NHS in Scotland. In theory, we could have done that without HEPMA, but the HEPMA expertise, as well as the integration and collaboration with colleagues in information technology and information governance, has allowed us to have the networks within the board to make that happen.

In relation to where we go next, I alluded earlier to the opportunity that we have to use the electronic IDL to support an alternative method of prescribing medication at discharge. We want to be able to use the data to inform prescribing decisions and medicine-usage figures in the hospital.

11:30

Brian Whittle: Thank you—that is what I call an insight. You were prepared for that. [*Laughter.*]

We get the feeling that HEPMA is a big step forward in data collection and usage. Is it easy for NHS Dumfries and Galloway to share that good practice and learning with other health boards? What are the barriers to doing that?

Graeme Bryson: NHS Ayrshire and Arran was the vanguard innovator. Until recently, the learning has been shared in an iterative way. When NHS Dumfries and Galloway looked at HEPMA, we had a lot of conversations with colleagues in NHS Ayrshire and Arran and, as NHS Forth Valley starts its roll-out, it will come into those conversations.

We also have the learning from NHS Lanarkshire's work on the national implementation pilot. That learning was supplemented by a report that Healthcare Improvement Scotland and NHS Forth Valley wrote about the learning points from the rapid roll-out. At the moment, that work is done through a specialist network of HEPMA pharmacists, pharmacy technicians and IT people. Pharmacy is quite a small family within the NHS in Scotland, so we tend to know one another, which helps to facilitate conversations.

Quite rightly, the national implementation programme will roll out in two phases, and the next few years will be very much about securing implementation. Our experience shows that, as with all IT solutions, there is a lot of expectation, so a fair bit of expectation management is being done in relation to what the new systems cannot do as well as what they can do. There will be a learning period. As the implementation phase ends and we start to look at where we go next with the data, we as a profession think that working with colleagues in IT and data analytics is where our strength will come.

Brian Whittle: It would be remiss of me not to raise the point to which Jonathan Burton and David Shackles alluded. How can patient data that is gathered through HEPMA be utilised, through IT, in primary care and community pharmacy?

Graeme Bryson: It is important for the committee to note that HEPMA is—I will say it again—a hospital electronic prescribing and medicines administration system; it is not designed to be a data analytical tool. I am no data analyst or IT expert, but my understanding is that we require to apply additional analytical software to the data that is generated from HEPMA, so that we can take, in essence, raw data and put it into a format that allows practitioners, whether medical, nursing, pharmacy or others, to interpret the data. The data is very powerful, but unless we apply quality improvement methodology in a multidisciplinary setting, it will be nothing more than data and we will not be able to make the most of it.

Jonathan Burton: Information sharing with primary care was mentioned. I work in NHS Forth Valley, and we in community pharmacy have been the beneficiary of a lot of the hard work that has been put into HEPMA at Forth Valley royal hospital. In practice, that means that, for the past three or four years, when a patient who has a regular community pharmacy is admitted to hospital, the community pharmacy, with the patient's consent, receives an admission note, so that it knows that the patient is in hospital. From a medicines waste and a patient safety point of view, that can be valuable information. Quite often, such patients can be elderly and taking several medicines, and they might receive a home delivery service from the pharmacy. Without an admission note, we would not know what was going on or where the patient was.

As in some of the other health boards, we receive the immediate discharge letters. Initially, they came via email, but in Forth Valley we have the pharmacy care record, which I alluded to earlier. It is the online tool that we use for our community pharmacy-based medication reviews. It also supports stop smoking services, gluten-free services and SBAR—situation, background, assessment and recommendations—communications for acute conditions.

We now have a hospital tab in that tool, where we access all our admissions and discharge information. It could be argued that it is still a little on the clunky side, but it is genuinely useful in practice, especially the discharge information, because quite often the community pharmacies and GP practices have to work hard to make sure that the patient is transitioned safely back into the community, so that medicines reconciliation happens. A lot of that meds rec work is done by GP practice pharmacists. There have also been pilots and there are situations in which community pharmacies naturally do a lot of that work, either formally or just as part of the day-to-day work.

Dr Shackles: I agree with a lot of what Jonathan Burton said. I work in NHS Tayside, which is at the early stages of discussing HEPMA in secondary care. We in general practice very much look forward to both the medicines reconciliation from the immediate discharge letters and improving some of the out-patient communication. At the moment, our secondary care colleagues are using technology for communicating with us that they do not feel is fit for purpose. Often, they will revert to communicating their medication changes in the letter to the GP that may come out some time later and will go to the general practitioner but not to the practice pharmacist, who might be best placed to make the required prescribing changes. So it has an effect, not just on the medicines management but on the workforce management in the practice.

Where there are good technological solutions that are coming out in variable ways, work needs to be done to make it a level playing field across the country to get everybody up to the same technological level.

Emma Harper: Having been a nurse and employee of NHS Dumfries and Galloway, I can identify with what has been said about searching for cardexes. I was part of the HEPMA implementation when it was first rolled out. We took evidence from a previous witness who said that writing a prescription by hand took him 30 seconds. I am interested to know how long it takes to input a prescription once somebody is trained on HEPMA. I understand that safety is an issue; I have had to query many cardexes and pieces of handwriting. I assume that, once HEPMA is up and running and people have been trained, it is quite easy to put a prescription in.

Graeme Bryson: Yes, that is correct. As you will remember, there is obviously a transitional period in which people make the cultural change to understand that the prescribing system is slightly different from what they have been used to. As we see it becoming more and more common across Scotland, we will see a consistency of approach. At that point, we will be bringing through our pharmacists, nurses and medical colleagues to that standard level. It is important to acknowledge that the HEPMA system is the first critical step that we need to take to improve the safe and cost-effective use of medicines in hospitals.

George Adam: As you can probably see, I am the only MSP here who is completely digital, with no paper to be seen in front of me—apart from a pad in case I need it. I will talk about technology, because there needs to be trust in technology to take things forward.

We have heard claims from individuals, organisations and companies that the medicines budget could be transformed by the use of technology and automation. They said that it would improve nurse efficiency and free up their time, reduce medication errors and wastage in hospitals and at home by improving stock control, which would drive things forward. In your spheres, do you agree with the benefits of automating the dispensing process in the Scottish NHS and pharmaceutical industry?

Adam Osprey: It is probably worth delving into what we mean by “automation”. Emerging, young evidence suggests that using robots for dispensing, certainly in a community setting, requires enormous scale to deliver efficiency.

There is another way of looking at it. Medicine makes its way through a pharmacy and must undergo a check for accuracy and for clinical appropriateness. The accuracy check does not have to be done by a pharmacist but, traditionally, it is. There are a number of emerging technologies around the country and several pharmacies have picked them up. To get good time gains for pharmacists, appropriately trained staff can be utilised to perform that accuracy check using barcode-scanning technology, which ensures that what is on the prescription matches the label and that the label is applied to the right medicine. That is possible because all medicine packs have barcodes now. There is huge potential to save time, which can be put into conversations with patients.

Dr Shackles: George Adam asked a good question. The previous panel talked about the fact that, once medications go on to patients’ repeat prescription records, they tend to stay there without being sense checked, reviewed or taken off. Medications can get stuck in a repeat prescription whether a patient needs them or not. We need good systems to ensure that, even in the interface between hospitals and primary care, we check that medications are still appropriate and required, rather than just going through electronically, which can easily happen.

George Adam: One of the companies that provided a submission to the committee was Omnicell. I think that it is already involved in Scotland, but it certainly has a dog in this race, because it is trying to sell tech to the NHS. In its submission, it says that technology can

> “Reduce hospital medicine and supplies stock by up to 40% ... Save hospital medicine and supplies consumption by 5-15%”

and

> “Reduce round times in care homes by up to 75% freeing up staff to deliver more care”.

Those are impressive figures, and Omnicell says that that can be done in various ways. Adam Osprey talked about robots earlier. Omnicell says:

> “For pharmacy this includes robotics, automated dispensing cabinets and intelligent trollies.”

That all makes sense to me, although I know that there will be a cost involved to implement most of it. Are we in a place where we could achieve those claims? Do you recognise those figures? Could technology make that much difference?

Further, are we in a place where we could trust the technology to deliver all that? Using MSPs in this committee as an example, I am the only one sitting here who is showing trust in the digital technology. Trust is a big issue with technology—are we in a place where we could do that?

Adam Osprey: Healthcare is a complex system, which you will probably have gathered an appreciation of over your time on the committee. Trust in the technology is emerging. I have been to demonstrations of robots and seen that their level of accuracy is impressive. However, there will always be humans around the technology, and it has to be borne in mind that a computer is only as intelligent as what somebody tells it to do.

I refer back to what my colleague Graeme Bryson said about culture change. Just throwing a piece of technology into a system does not automatically bring new efficiencies; it needs to be carefully managed into place.

There is probably not a black-or-white, yes-or-no answer to the question of whether we should adopt such technologies. We probably need to spend time carefully researching the best ways and where each individual piece of technology fits. A robot for hospitals might deliver some great efficiencies that would not work in community pharmacies, because those are two fundamentally different business models and ways in which patients access services.

Graeme Bryson: I apologise if the committee is already aware of this, but it would remiss of me not to highlight it. As part of the chief pharmaceutical officer’s achieving excellence in pharmaceutical care strategy, the Scottish Government commissioned a review of robotics in community pharmacies. I am unaware of the particular companies that were involved in that; I do not know that level of detail. We are expecting to have the report of the review back in the middle of the year.

11:45

Alex Cole-Hamilton: We have learned a lot during our inquiry about the influence of the shallow dive into knowledge that a lot of patients make by googling their symptoms and identifying treatment pathways, including drugs of choice that they might like to be prescribed, although their consultants and GPs might have other ideas. Similarly, pharma companies have got better at marketing, using platforms such as social media to do so. How common is it for patients to want access to medicines that are not necessary for their conditions? Is there a way in which we can inhibit or address that head on?

Adam Osprey: From my experience of community pharmacy, I can say that it is very common. There are two ways in which a patient will try to access medicine: either by coming to us with symptoms that need to be assessed, or by coming to us with a direct product request, although generally not for prescription medication, because people realise that they will have to go through their GP for that.

Over the past three years, the Scottish Government has put a lot of investment into education and training in the community pharmacy network to enable and empower community pharmacy teams—the whole team—to open up a direct product request into a consultation. That is the premise for NHS pharmacy first—I will sneak in a mention of it here—which is the replacement for the minor ailment service. We talked earlier about promoting that service, which is all well and good, but we need to be careful about the language that we use when we do so. It is a consultation service, through which we encourage people to bring their symptoms to us, which I think will help to change the behaviour of self-selecting when what is needed is the assessment of symptoms. We have even gone to the effort of working with our Scottish Government colleagues to structure the funding such that it does not matter whether the outcome of a consultation through the NHS pharmacy first service is only that advice is given or whether something is prescribed or the person is referred on. That means that there is no incentive to provide, which will help with patient expectations—that theme arose earlier in the meeting. We need to set the service up for success by helping people to understand that they should not necessarily expect to walk away with anything when they access the service, and that that is okay.

Dr Porkess: It is also important to remember that pharmaceutical company activities in the UK are governed by the Human Medicines Regulations 2012 and there is a self-regulation code. For prescription medicines, companies are not allowed to promote to patients, so any promotion that companies do has to be to healthcare professionals. There are very strict quality standards to make sure that what companies say is fair and balanced and describes not only the benefits but any potential risks of the product, which helps the conversation between a healthcare professional and a patient and makes sure that they have the right information.

Dr Shackles: I think that those conversations are becoming more common. Patients are increasingly well informed by the internet and will often ask why they are on one medication rather than another. Therefore, it is incumbent on us to have such a discussion to explain. We have discussions about local formularies and why certain medications are prescribed or not prescribed. Increasingly, we are referring patients back to decisions of the Scottish Medicines Consortium about why certain medications are not available, although we recognise that newer or more novel medications are becoming available and we often refer patients back to specialists to consider those medications when it is appropriate to do so.

Such discussions are becoming much more commonplace, but we need to have more in-depth consultations with patients and use more complex decision aids to explain decisions to patients in ways they understand, by using information such as Cates plots—you might be aware of the 100 smiley faces diagram that can be used to help patients to understand why a medication might or might not be appropriate for them. Of course, all such discussions take increasing amounts of time from what we are trying to do. We have already heard about trying to maintain our access, so we feel that we need more time to have those useful discussions, which may give better care to patients.

Alex Cole-Hamilton: Finally, does the panel believe that the pharmaceutical industry is driving up consumer demand? Are patients becoming more informed about pharmaceutical interventions that might be available? Are they asking for specific branded products when generic medicine is available at lower cost, and do their expectations need to be challenged in that respect?

Adam Osprey: The controls that my colleague has described in relation to the pharmaceutical industry's activities in respect of direct patient marketing are very robust in this country. On the question of over-the-counter medications, many people who come in to have their symptoms assessed are looking for a specific product, but we have designed the new NHS pharmacy first service so that there will be an approved list of products that are generic and will be prescribed and supplied as generics. If a patient is adamant that they would prefer a branded product, that is fine—they will have the option to purchase that product, but they will still get the benefit of the advice from the service. Getting people used to the message that a certain option is effective and safe for them and that we have a lot of experience of using it is a behavioural and cultural thing that we will have to learn as we go along.

Graeme Bryson: An informed patient is an engaged patient. Pharmacists and pharmacy technicians would welcome more realistic medicine conversations with patients, as Adam Osprey suggested. If we are serious about improving things, we have to do that in collaboration with our patients.

Jonathan Burton: The pharmacy where I work has an active walk-in service that covers minor ailments, pharmacy first and an independent prescriber-led walk-in clinic. Increasingly, when we talk to our patients, they say, “That’s kind of what I read on Google.” Patients are coming to us better and better informed. Sometimes they will have hit the nail on the head for their symptoms or medicine requests, and sometimes they are a little bit off the mark. It is our job to work with them to ensure that the treatment choices that we make are safe for them.

I agree that the systems that we have in place on direct-to-consumer marketing are robust. That makes our life in practice a lot easier. That is not always the case with some over-the-counter medications and we need to think carefully about the way in which some substances that are liable to misuse are marketed to the public. That is something that needs more attention, although it is perhaps a conversation for another day.

We are seeing better-informed patients. The world of information is open and we need to tailor our services around that. We should be quite grateful when patients come to us having done a bit of their own research, because we should be banging the drum for self-care and for people to have a self-care plan. We talked in previous meetings about educating people from a very early age—school age—about the basics of looking after themselves and when to seek help. In that way, we will end up with GPs who are doing what they should be doing—they are the experts in undifferentiated diagnoses and looking after people long term—community pharmacists who are seeing the right type of patients for our pharmacy first service and a lot of patients who are able to look after the basics themselves.

Dr Shackles: I absolutely concur with that sentiment. We regularly get letters from patients asking why they are not being given a certain branded medication and, more often than not, that will be followed up by a letter from their MSP asking why they are not being given that branded medication. We then have to spend quite a lot of time writing back to explain that there may be no clinical indication—such as no allergy—for giving a branded medication rather than a generic medication.

There are occasions when a branded medication might be more appropriate and that is then seriously considered by the GPs. We are not barriers to providing the right medication to the right person at the right time.

The Convener: I thank all the panel members for their evidence today. We may be in touch if there are matters that you have mentioned that we would like to hear more about. Our final session of evidence in the medicines inquiry will be with the cabinet secretary on 10 March. We look forward to that.

11:55

Meeting suspended.

11:57

On resuming—

Birmingham Commonwealth Games Bill

The Convener: Item 2 is consideration of a legislative consent memorandum relating to the Birmingham Commonwealth Games Bill. Part 3 of that bill relates to areas that fall within the legislative competence of the Scottish Parliament, and the committee needs to agree—or not—for those areas of devolved competence to be considered by the United Kingdom Parliament.

Members will recall that the committee has already considered and reported on a legislative consent memorandum relating to a bill covering this topic, but that bill fell at the dissolution of the 2019 session for the general election. A new Birmingham Commonwealth Games Bill was introduced in the House of Lords on 7 January 2020. A new consent memorandum was lodged on 30 January 2020, and that is what we are considering today.

Is the committee content with the LCM and with the Scottish Government’s view that the Scottish Parliament should consent to the UK Parliament legislating in this area?

Members *indicated agreement.*

The Convener: That is agreed and we will report to the Parliament on that basis.

11:59

Meeting continued in private until 12:09.

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