OFFICIAL REPORT
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Health and Sport Committee

Tuesday 10 March 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
6th 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:

Jeane Freeman (Cabinet Secretary for Health and Sport)
Bryan Lamb (Scottish Government)
Alpana Mair (Scottish Government)
Professor Rose Marie Parr (Scottish Government)
Professor Alison Strath (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 10 March 2020

[The Convener opened the meeting at 11:18]

Medicines (Supply and Demand)

The Convener (Lewis Macdonald): Good morning, and welcome to the sixth meeting in 2020 of the Health and Sport Committee. I ask everyone in the room to ensure that mobile phones are in silent mode and that mobile devices are not used for photography or recording proceedings.

The first item on our agenda is our final evidence session as part of the committee's inquiry into the supply of and demand for medicines. I welcome our witnesses. Jeane Freeman, the Cabinet Secretary for Health and Sport, is accompanied by Rose Marie Parr, who is the chief pharmaceutical officer; Alison Strath, who is a principal pharmaceutical officer; Bryan Lamb, who is head of the pharmacy branch; and Alpana Mair, who is head of effective prescribing and therapeutics, all from the Scottish Government.

It is important to acknowledge at the beginning of the meeting that everyone's time is perhaps tight in the difficult circumstances in which we are operating, so we will endeavour to be as focused and concise as possible. I am sure that the cabinet secretary will wish to take the same approach. I invite you to make an opening statement, cabinet secretary.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, convener. Point taken.

Before I start, I want to convey the apologies of Dr Gregor Smith, who is our deputy chief medical officer. I know that he has advised the committee of this, but this morning he is with the scientific advisory group for emergencies. I am sure that you will appreciate the reasons for that.

I thank the committee for inviting me to give evidence as part of your inquiry. I am sure that, from the four evidence sessions that you have held, colleagues know that the issue of the supply of and demand for medicines is diverse and complex in nature, and that real change requires a whole-system approach from manufacturers, wholesalers and prescribers to supply to individuals, how they use their medicines and, finally, how unused medicines are disposed of.

Medicines prevent, treat or manage many illnesses and conditions, and they are the most common intervention in our healthcare system, so it is important that we get the most from them, for patients and for the national health service. That is becoming increasingly important as the health and social care sector treats and cares for more people in our society. We have an ageing population in which people are living longer with multiple long-term conditions. More people with complex conditions are being treated at home or in their communities with medicines that historically were used only in hospitals. That is because we know that that care location provides the best outcomes for patients.

In the face of those challenges, the NHS in Scotland tries to ensure that we deliver the best value for money with the medicines that are purchased. In 2018-19, NHS Scotland spent around £1.7 billion on medicines. Most medicines were dispensed in the community, at just over 103 million items and a cost of around £1.3 billion. Although the total number of items that are dispensed to patients has steadily increased over the past decade, we saw a fall of £6 million in the net cost of medicines from 2017-18. That fall is welcome and is testament to the hard work of the health service, general practitioners and pharmacists in delivering effective prescribing for patients.

The voluntary pricing access scheme—VPAS—for branded medicines is one mechanism by which the United Kingdom Government seeks to control the cost of branded medicines to the health service. The scheme aims to ensure predictability and stability, for Government and the pharmaceutical industry, and to ensure that the cost of branded medicines to the health service stays within affordable limits. The scheme places a 2 per cent cap on the growth in sales of branded medicines for each year of the scheme, and pharmaceutical companies repay the NHS for any spending above that cap.

The Scottish Medicines Consortium, with which the committee will be familiar, has a critical role to play as the national source of independent advice on the clinical and cost effectiveness of all new medicines for the health service in Scotland. The consortium's work ensures that people have timely access to new medicines that provide the most benefit, based on the best available evidence.

Community pharmacists undertake a key role in the procurement of medicines in primary care by responding quickly to changes in the marketplace and driving down the prices that are charged by wholesalers and manufacturers. However, procuring medicines effectively is only one piece of the jigsaw; effective prescribing strategies ensure safe and effective prescribing and use of

medicines. It is important that we focus on the priorities of realistic medicine and the national clinical strategy in applying evidence-based prescribing in primary and secondary care.

Since 2012, we have had in place a policy that addresses holistic prescribing: "Polypharmacy Guidance: Realistic Prescribing". Eleven per cent of all hospital admissions are attributable to medication-related harm, and half of those are preventable, so the work reduces harm and waste. Integral to that is a patient discussion on adherence. Until 2012-13, there was an annual volume increase of 3 per cent. Since the introduction of the first polypharmacy guidance in 2012, the rate of volume increase has fallen each year.

The introduction of the pharmacotherapy service in around 70 per cent of our general practices as a result of phase 1 of the GP contract means that pharmacists and pharmacy technicians are now embedded in the general practice team, who can provide medication management systems, including formulary compliance, hospital out-patient requests, medicine reconciliation and repeat prescribing management. They can also provide polypharmacy and medication reviews, including of high-risk medicines, and take on the management of people with more complex multiple conditions, which involves taking decisions with individuals on the use of their medication and, where appropriate, monitoring and adjusting treatment prescriptions. By taking on that role, those pharmacists are improving clinical outcomes for people, reducing the workload of GPs and freeing up the capacity of others to focus on people with undifferentiated illness or other complex needs.

The pharmacy profession as a whole has a key role to play in empowering people and the carers who support them to make best use of the services that are on offer. We are strengthening and refreshing the chronic medication service to improve its ability to enable community pharmacists to improve personalised care for people with stable long-term conditions. As experts in medicines and their use, pharmacists play a crucial role in supporting people to use their medicines to achieve the best clinical outcomes.

The launch, this April, of our new NHS Scotland pharmacy first service will allow individuals to receive a consultation with a member of their pharmacy team and to receive advice on treatment, including self-care for minor illnesses and self-limiting conditions, or referral to another healthcare professional, if appropriate.

Alongside all that, we must consider the impact of social prescribing in helping patients to self-manage and achieve better health outcomes in place of, or in conjunction with, prescribed medicines.

It is worth highlighting that not all prescribed medicines wastage is avoidable or the result of poor practice. We are more likely to improve health outcomes by focusing on better medicine use and improving adherence, as opposed to waste reduction on its own.

We continue to focus on improving the quality of care and achieving better health outcomes for the population and, in particular, for people with multiple and complex long-term conditions. That requires improving pathways of care through the use of integrated multidisciplinary teams, which is an approach that is preventative, anticipatory and proactive in nature. I look forward to the conclusion of the committee's inquiry to help us to move further along that road.

The Convener: Thank you very much, cabinet secretary—that is much appreciated.

A theme that has come up in this inquiry, as it has in others, is the collection of data and the use of technology to improve outcomes. Could you bring us up to date on the work that is being done on the digital platform and, in particular, on timescales for delivery? How will the digital platform help with the prescribing and dispensing of medicines?

Jeane Freeman: I will start and either of my two colleagues will follow through.

NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Forth Valley and NHS Lanarkshire have implemented or are close to completing implementation of the HEPMA—hospital electronic prescribing and medicines administration—programme. Other boards, including NHS Lothian, which is partnering with the state hospital, and NHS Greater Glasgow and Clyde, are working through their design and/or their implementation. Our expectation is that the majority of boards will have concluded the implementation of HEPMA by the end of this year, with perhaps only one or two of the smaller boards still having to complete that work.

As far as other work is concerned, including on data collection and effective prescribing, I will ask our chief pharmaceutical officer to respond.

Professor Rose Marie Parr (Scottish Government): The cabinet secretary is right to tell a good story on the pace and traction of the introduction of HEPMA across our secondary care services. The committee will know, because it has received a lot of evidence on data and outcomes, that we are talking about a piece of the jigsaw on which there is not as much illumination on prescribing and outcomes in secondary care as there is in primary care.

HEPMA is important, and we can think about how we improve on HEPMA so that it is not just a safe prescribing system but looks at what happens to patients when they take their medicines. Has there been harm or benefit? How can we measure that benefit?

11:30

We are not alone in the world in having difficulty in measuring benefits from medicines, particularly when people are co-prescribed lots of medicines or have lots of illnesses. There is a golden nugget in thinking that the issue is about not just access to medicines or new medicines but healthcare interventions and health outcomes or gains, which are important. The work that we want to do certainly involves outcomes and data. The Montgomery review has pointed us in that direction, and HEPMA will be part of that, too.

On outcomes and data, the Scottish Government has recently pump-primed the cancer medicines outcome programme—CMOP—which I hope the committee has heard about. That is a positive start to looking at where we might be in the future. The programme applies only to cancer medicines just now, but we are looking at how medicines are used in real life, and not just in clinical trials or in controlled conditions. That will make a difference not only to the work on cancer but in other areas. We are happy that that programme will be funded over the next few years. It has looked at aspects of myeloma, prostate cancer and other areas. The service will gain from the roll-out, and other aspects of medicines will be looked at, too.

We definitely want to maintain our efforts and energy in looking at the life cycle of a medicine—not just access but health gains and outcomes.

Brian Whittle (South Scotland) (Con): I will follow on from the convener's question. Some patients who arrive in secondary care are already on medication. They then go to primary care with medication. Is the thinking to link the HEPMA system with primary care and community pharmacy, so that proper throughcare and proper mapping out follow the patient and their medication?

Jeane Freeman: Yes, it is.

Professor Parr: Brian Whittle is absolutely right: that is the thinking. It is part of the jigsaw. We also have to put other things in place. The national digital platform and a shared medication record will also be important, and people are working on those things just now. If we have a shared medication record and access to data across those boundaries, we will reduce the harms that medicines can cause. We know that most harm happens when people cross boundaries when they are admitted to or discharged from hospital. The national digital platform and the shared data requirements are important.

It is also about what we do with patients' medication when they come into hospital. I know that the committee has been interested in patients' medication and how we can usefully keep patients integrated with their own care, which is important. There are some good examples of health boards doing that.

We should also look at the discharge programme and what happens when people come out of hospital and secondary care and go into the community. We should look at innovative ways of making that move a bit more seamless. The committee has heard evidence on using patients' medication and on joining up community pharmacy and the discharge programme. There are definitely some interventions that can lead to a smoother integrated pathway across the piste.

Jeane Freeman: As Rose Marie Parr said, at the moment, boards have their own policy on the use of in-patients' medicines and on the use of those medicines when patients are discharged. I am sure that we have all heard examples of people saying, "I went into hospital with my own medication and they took it off me. Then, when I left, they gave me a brand new prescription." Understandably, people perceive that as waste. Not all boards do that.

Boards should allow patients to manage their own medication, subject to a risk assessment. We are looking to ensure that that policy is in place across all boards, so that all patients are treated in the same way.

Of course, while someone is an in-patient, they might have additional medication for a short period. We need to make it much more about what the patient needs and wants to do and less about different policies between boards.

Brian Whittle: Thank you. May I clarify something? We have been talking about developing a national digital strategy and platform, but each health board has a certain amount of autonomy, even on how HEPMA is developed and delivered. How do we marry that autonomy with a national digital strategy that works throughout the country?

Jeane Freeman: That is a good question. We have to be able to work closely with the people who are in the relevant areas in boards, so that we create a national approach that allows for local difference, where the reason for local difference can be evidenced. I hope that that makes sense.

Almost all boards will have evidence that suggests that they should tweak a national approach in a particular way—across a range of

things that I am sure that you and I could both think of. Just creating and imposing a national policy will not work. Similarly, every board having a different approach will not work.

We are managing that, for example, even in the context of human resources policies. We have a suite of single HR policies that are applied in all boards but which were created nationally, with the involvement of board HR directors and—importantly—unions.

The approach that we take to get there is the key to how successful delivery will be.

Emma Harper (South Scotland) (SNP): Who is ultimately responsible for the roll-out of HEPMA? NHS Dumfries and Galloway rolled out HEPMA about four years ago. Are some boards testing the system and figuring out all the problems before wider roll-out takes place? Is the system being imposed on all boards at the same time?

Professor Parr: There are governance systems around HEPMA, as it receives more funding and gathers pace and traction. There is shared learning around the country, with boards that went early helping the bigger boards that are about to go. There is a governance reporting system. The HEPMA oversight group reports and there is the e-pharmacy board. Reports go to the health and social care management group.

We want to get the big gains from HEPMA and to work as much as possible on a once-for-Scotland basis—even if that is not the right fit; it is about learning from areas that have used the system. With most electronic prescription systems, the problem is generally public behaviour and how people prescribe, rather than the information technology. People are used to prescribing in certain ways and might have to change their mindset.

Emma Harper: Do some boards use a different HEPMA system? We took informal feedback after one of our meetings and heard that the Glasgow doctors who are training in Dumfries absolutely love HEPMA and cannot wait for it to be rolled out in Glasgow. Will it be the same HEPMA, though?

Professor Parr: There is governance around that, too. Boards have to make business cases and tender for HEPMA systems. Scotland is well joined up in that regard and is learning the lessons across the piste. We realise that for a junior doctor who has to move from Dumfries to another area, it will be helpful if the systems are similar. We are working towards that type of co-operation.

As a postscript, I should say that although boards do some things differently they also do things in joined-up ways. The north of Scotland is collaborating on HEPMA on a much more regional basis, and the approach there will provide learning to share with the other regions.

Emma Harper: If electronic prescribing is rolled out by December 2020, that will be good news, because HEPMA is a good approach in terms of safety and reducing medical errors. I say that as someone with experience of HEPMA's implementation in NHS Dumfries and Galloway. We look forward to the roll-out.

Jeane Freeman: They will come on at different stages. NHS Lothian, which is partnering with the state hospital, will go live this month. They are at different stages, and we expect to see all bar one or two going live by the end of the year. The Golden Jubilee hospital is at an early stage and might go into January next year.

The Convener: Can we confidently forecast that HEPMA will be up and running by this time next year?

Jeane Freeman: I think that that is fair.

George Adam (Paisley) (SNP): I would like to ask about licensing of drugs. I will give you some background so you will know why I am asking the question. You will not be surprised to know that it is about multiple sclerosis. I have been speaking to a Glasgow neurologist who also covers Ayrshire, who says, in effect, that some drugs that are licensed for other conditions might be used for MS treatment, and might be cheaper than some of the drugs that we currently use.

During one of our evidence sessions, the committee heard from Dr Scott Jamieson of the Royal College of General Practitioners. He told us:

> "Where there is a licensed medicine for an indication, the guidance states that I should use it for that indication. If I did not use it for that indication, I would need to justify, on an individual patient basis, why I preferred not to do so, even if the licensing was not based on efficacy."—[*Official Report*, *Health and Sport Committee*, 28 January 2020; c 32-33.]

How can we sort that? Can we sort it? Is it a pharmaceutical manufacturer problem, or is there a better way that we can do that?

Professor Parr: I will start, and Alison Strath may want to come in.

That is a good point. We have one of the most scrutinised systems for medicines governance across the piste. You will know how we do our research and development through clinical trials and looking at aspects of how medicines are licensed and come to the market. They are marketed with that marketing authority, and we also have our health technology assessment. There are lots of governance systems for how we license medicines. We are also hooked into the European Medicines Agency, and it and the Medicines and Healthcare products Regulatory

Agency will continue to be important in how we license medicines in Scotland and in the UK.

Licensed medicines are generally for a particular purpose, but that does not mean that that is the only way that drugs can be used. Boards have policies for using medicines that are off-licence or off-label. They have scrutiny and governance for how that can be done safely. Clinicians can write prescriptions for those drugs if they wish to do so. They have to look at the system of governance within their board. That governance comes from area drug and therapeutics committees, from formularies and from their system for how they sign off either licensed or unlicensed medicines. Alison Strath may want to add to that.

Professor Alison Strath (Scottish Government): There are two types of unlicensed medicines use and it might be useful to distinguish between them.

One is when the medicine is genuinely not licensed, and the other is when we use a medicine off-label if it has been licensed for some other purpose. I think that is what your question is about. We use a lot of medicines off-label in that way. Most medicines are not tested on children or pregnant women, so we use them off-label with those groups, following the best available evidence as we make decisions about how to prescribe them effectively.

George Adam makes a good point about how we can find that medicines have additional uses as they go through their life cycle. Thalidomide is a good example of a medicine that we now use in cancer treatments for myeloma, although it was originally licensed for a very different purpose.

We have funded a piece of work that is being supported by Healthcare Improvement Scotland to test how we might use some medicines off-label and how we might create a governance structure for that. We have started by looking at cancer medicines because a number of those fall into that category. What we learn from that will help us to think about how we link our policies.

As the cabinet secretary and Rose Marie Parr have said, health boards are responsible, through area drug and therapeutics committees, for the governance arrangements for how medicines are used. We have an area drug and therapeutics committee collaborative, which represents all the area drug and therapeutics committees. We can work with it to think about where there can be benefits to standardising processes or to applying more similar processes so that we can learn lessons and share best practice.

We will work with the area drug and therapeutics committee collaborative to develop the work that we are doing on the use of cancer medicines off-label and to think about how that might apply to other medicine use.

Jeane Freeman: From what I understood about the evidence that you have heard, it occurs to me that we might need to look at how well understood the current governance process is. Given that it is possible to prescribe a medicine off-label, as my colleagues have explained, if we have clinicians who feel that they cannot do that, it means that there is a gap in the information and understanding that we are ensuring that they have.

11:45

At the moment, scientists are testing existing antiviral medicines to see whether they will be in any way effective for coronavirus. It is not unusual and in that case, those are being actively tested. Our clinicians and our prescribers need to understand what to do.

George Adam: That is part of the issue. Health boards in general seem to be very reluctant to look at anything slightly different or to go down that route. I am talking from a practical day-to-day perspective—that is what I hear from constituents and others. I know that we often hear about such and such a wonder drug that will make a difference to everyone's life—I am aware of all that. However, surely there must be an easier way to do it. I take on board what you are saying about health boards, but up to now they have not seemed to be proactively looking at such things.

Jeane Freeman: I am not sure that that is entirely fair. We need to remember that much of the governance around the prescribing of drugs is there for very good reasons. Some of it has arisen because of very serious instances of abuse that have significantly harmed patients.

We need to be mindful—as I know you are, Mr Adam—of what is appropriate governance to ensure that we learn lessons from things that have gone wrong and what keeps people safe and where there might be one or two layers of governance that are not critical to either of those two objectives.

I am happy to undertake to speak to that national group network and the committees that Alison Strath has just described, to see whether there is any way for us to streamline the process in any way, and to ensure that prescribing clinicians know what the current route is and what they have to do in order to prescribe off-label—they are not forbidden from doing that.

The Convener: Could anything be done to encourage pharmaceutical manufacturers to apply for a licence for an alternative or additional purpose? If so, who should be doing that?

Professor Parr: That is a very good question. We encourage the pharmaceutical industry to be innovative and to come back in for reassessment if they have to look at licensing or their health technology assessment, or for an extension of their licence. In general, some of our innovation can encourage that.

In general, we are entering a new era of more precision medicine, which is more stratified across the population. Those areas will be really important. We see some older medicines being repurposed and used for very different things. There needs to be some consideration of that huge burden on some parts of pharmaceutical industry to get their medicines to licence—that is very costly and takes time. Some of those processes could be shortened a bit, which would help.

Professor Strath: There are some challenges, particularly when a medicine is very old and is now generic. Such medicines will be manufactured by different companies, and they are less likely to be able to put the medicine through the clinical trial process to get the data to allow it to be licensed for a new purpose. As Rose Marie Parr said, we would need to work to understand what levers there might be to support repurposing in that situation.

The Convener: Those are not insurmountable difficulties.

Jeane Freeman: It is fair to say that they are not insurmountable, but some of them are more challenging than others.

Sandra White (Glasgow Kelvin) (SNP): I want to expand on the points about licensed medicines and talk about Brexit and other trade negotiations. We heard from representatives of the UK Department of Health and Social Care about the potential for trade negotiations to affect the price of medicines. They assured us that there is no intention to have prices on the table, as such. However, others who gave evidence suggested that prices might be affected by increasing patent lengths.

Has the Scottish Government analysed the potential effect of increased prices from US pharmaceutical companies? Brexit might also have a role in that. In Scotland, for example, are increased prices more likely to reduce access to medicines or increase the prescribing budget, or perhaps both?

Jeane Freeman: I will ask my colleagues to come in on what would be particularly important for medicines in any trade deal, especially around standards.

At this point, it is too early to answer your question definitively. My colleague Mr Russell is much more actively engaged in discussions with the UK Government about the negotiating position on any trade deal. We are making clear to him across a number of areas what is important to us on standards of governance, patient safety, and regulations that we want to see replicated.

We are also in contact with colleagues at Westminster and in the UK Government about the Medicines and Medical Devices Bill, which has just been introduced in the UK Parliament for consideration and which deals with our replacement for the European system that we have been part of.

At this point in time, it is difficult to judge whether a potential trade deal with any particular country would have a serious cost implication for us. We spend a huge part of our NHS budget on medicines, and we strive to get best value for money and to follow some of the Montgomery recommendations on our role in discussions with pharmaceutical companies. However, at this stage, it is much more about the key red lines for the Scottish Government in any trade deal negotiation that involves drugs.

Professor Parr: I will start off and Alison Strath might want to talk about the recent bill.

The issue is complicated for us, because many of the powers on medicines are not devolved, which goes some way towards showing where we are at this point in time. You will know that there are branded and generic medicines, and that the company that has the branded medicine holds the patent for a number of years. That is important for the pharmaceutical industry, to allow for the research and development in bringing those medicines to the market.

The regulation of pricing and supply of medicines and medical supplies is reserved to the UK Government, along with the licensing and marketing of drugs. The human medicines regulations are reserved, as are health service medical supplies and the controlled drugs regulations.

Although we have a good relationship with our Department of Health and Social Care colleagues and with the Medicines and Healthcare products Regulatory Agency, which is important in all these areas, we are also party to the devolved Administrations feeding into the cross-UK system. It is complicated. We have control of many levers, but there are others that we do not control.

To come back to European Union exit and the recent bill, it might be helpful if Alison Strath outlined a couple of points.

Professor Strath: Rose Marie Parr has touched on the issue of licensing, and one of our key concerns is about what happens after the

transition period when we come to 1 January next year, and how our processes deal with the licensing of medicines and their availability across the UK.

We are working closely with our colleagues in the Department of Health and Social Care and the Medicines and Healthcare products Regulatory Agency to ensure that we remain an attractive country for companies to launch their products. Normally, companies launch products in America first, then in Europe, then in Japan and then in other countries, which is called third-country launch. It is important for us that the UK remains at the top end of that list, and that we are an attractive place for companies to launch their products and make them available for patients, so that we can get the best possible outcomes. That is a big piece of work for us. Alongside that, we are analysing the risks and benefits of trade negotiations.

The UK Parliament Medicines and Medical Devices Bill will not actually introduce new legislation on licensing; it will introduce levers to allow us to look at new legislation on licensing and how we make precision medicine and some of the new advanced therapies available to patients in hospitals and in communities as appropriate. That is a big piece of work.

It would be helpful if the committee could encourage our colleagues across the UK to work together so that consideration is given to health technology assessment in Scotland as well as what may happen in England, Wales and other parts of the country. That would be useful, to allow us to work in a way that means that the SMC gets access to newly licensed medicines as quickly as possible, so that decisions can be made on their availability across health boards.

Sandra White: I have a brief follow-up question. You may either nod yes or shake your head no. For clarification, is the Scottish Government involved in talks about that new piece of legislation? That is really important.

The Convener: I see Professor Strath nodding. That is not going to work in the *Official Report*, so a yes would be good.

Jeane Freeman: Yes, there have been talks at official level. At political level, that is fed through by Mr Russell. It is an important issue. Colleagues will be aware of the significant advances in precision medicine in Scotland, which are being led not only by our academic institutions but by others that are actively engaged in this area in Scotland. We have real possibilities here, by reason of our data storage and protection around it, our size and the capacity of our universities to co-operate well. I do not want the NHS in Scotland, and therefore patients in Scotland, to lose the gains that will come from that significant work. As Alison Strath says, it is important that we stay at the top of the launch league table.

The Convener: I would like a simple yes or no answer to this: should we expect a legislative consent motion in relation to the bill that has just been introduced at Westminster?

Jeane Freeman: Yes, in respect of any aspects that are appropriate to Scotland.

David Stewart (Highlands and Islands) (Lab): I will move on to pricing. What assessment has the cabinet secretary made of the effectiveness of the current model of pricing in encouraging innovation in the sector?

Jeane Freeman: By that, do you mean the role of the SMC?

David Stewart: Yes, and in particular the use of VPAS, which is the branded drugs price regulation scheme.

Jeane Freeman: VPAS has helped us considerably since it was introduced in 2019. Any spending above the cap is paid back to the health service, so we can use it to support access to new medicines. Alison Strath may wish to speak about whether we could do more with that scheme. She was directly involved when we worked with Vertex Pharmaceuticals to see whether there were other ways to introduce new medicines. That was in anticipation of the impact of precision medicine, which we have just talked about. We will start to see the development and introduction of medicines that are targeted at smaller cohorts of patients and so might fall outside our current approach.

12:00

Professor Strath: At a simple level, as a result of the VPAS arrangements, once we go over the cap, the more we spend on medicines, the more money we get back from the pharmaceutical industry. We expect that we will get back about £93 million in Scotland for 2019, and we have reinvested that money in the NHS. The money has supported the new medicines fund, which is used for access to medicines that are approved by the SMC and those that come through the peer-approved clinical system tier 1 or 2 process for medicines that have not been approved for routine use.

Two key factors in the VPAS negotiation that were important from a Scottish perspective were achieving greater transparency on pricing—to ensure that a medicine price agreed in one part of the country was shared, so that we could have a conversation and other parts could have that price—and the ability for companies to proactively work with us to achieve those comparable pricing

arrangements. Those levers have been important to help us to deliver the recommendations on achieving better pricing in Dr Brian Montgomery's review on access to new medicines.

Rose Marie Parr has discussed the reserved versus devolved issue, and we have spoken about the challenge that the regulation of medicine pricing is a reserved power, so we are limited in our flexibility around that. The VPAS arrangement has allowed us to introduce greater flexibility to help us to ensure that we achieve the best value for Scotland.

David Stewart: My next question is about how the rest of the UK operates. I understand that the power is reserved, but does the Scottish Government have a team that monitors prices and products in Northern Ireland, Wales and England?

Professor Strath: We work closely with NHS National Procurement, which is our body that is responsible for procurement issues. Our team, the medicines and pharmacy division plus National Procurement colleagues work together closely. We are setting up arrangements that will allow information sharing between the organisations that are involved in pricing and negotiations on price, so that we have sight of the prices and can enter negotiations about them.

David Stewart: If, for example, England and Wales had a better arrangement on a drug than Scotland, would you pick up that best practice for Scotland?

Professor Strath: We would certainly work to do that. The cabinet secretary spoke about our work on cystic fibrosis medicines, when we worked collectively across the UK to achieve comparable arrangements so that we all get the same value from pricing. We need to consider the different parameters that are sometimes attached to deals. In England, there is a cancer drugs fund, for which data is collected. We would want to think about whether to do exactly the same or to adjust it. We have the flexibility to allow us to think about what would work best in Scotland and how to support our clinicians to collect the data and feed back.

David Stewart: You have obviously left it open to me to ask whether we need a cancer drugs fund in Scotland.

Professor Strath: No, I do not think that Scotland needs a cancer drugs fund. That would create its own problems.

The Convener: We will come back to that another day, I am sure.

Professor Parr: Scotland is in an important position. Just after this evidence session, we are going to a meeting to talk about the voluntary scheme ambition. We are talking to Department of Health and Social Care colleagues about ambitions to encourage horizon planning, engagement with companies, bringing people into the market, looking into price transparency and the National Institute for Health and Care Excellence arrangements for health technology assessments.

If I were being kind, I might say that, because of its size, NICE sometimes overwhelms some of those discussions, and we have to remind our colleagues in the Department of Health and Social Care that the SMC is also important. Our health technology assessment is internationally renowned and well thought of, but we also have some different systems, such as the new medicines fund. We put all the VPAS money back into medicines, but other systems do not do that. We have to keep reminding the UK systems that Scotland is here and is important.

David Torrance (Kirkcaldy) (SNP): Good afternoon, cabinet secretary and panel members. The committee has heard evidence about inequality in scrutiny of medicines compared with scrutiny of other healthcare interventions. Should there be similar scrutiny of other healthcare interventions? Will you address that issue?

Jeane Freeman: Are you referring to the degree of robust scrutiny and clinical trial of medicines compared with medical devices?

David Torrance: Yes.

Jeane Freeman: The MHRA is the relevant UK body, as we have already said, and its remit also covers medical devices. The Government has raised concerns with the MHRA, which we continue to pursue, about the robustness of its assessment and testing process for medical devices, compared with what we rightly require for medicines. Our argument has crystallised around use of mesh in surgical procedures, because devices and medicines that are put inside a person's body are equally important. We continue to press the MHRA to make its process for medical devices comparable with the process that we all expect for clinical trials, licensing and so on of medicines.

We have raised the matter directly with the MHRA, as has the chief medical officer for Scotland, and we continue to pursue it. We have touched on the Westminster Government's Medicines and Medical Devices Bill, which has a particular purpose, but I am in no doubt that markers will be laid down in the discussion and debate on that bill, as it goes through its various stages, about trying to improve the MHRA's process.

David Torrance: Thank you. The committee heard that reviews of non-medical prescriptions do not take place comprehensively or routinely and that GPs do not believe that they are best placed

to do that. What is your view on that, cabinet secretary?

Professor Parr: I am happy to take that question. On scrutiny of medicines versus that of devices, scrutiny of devices is, in some ways, a new field for the MHRA, so we continue to press it on the matter. Antibiotic resistance is a good example for which we have developed a new app from which people can learn and share information. However, the app must be compliant with MHRA requirements and that type of governance system. Healthcare professionals will see things quite differently in the future: I hope that our systems regulation will cope with that.

I go back to repeat prescribing across the piste. We are entering a new area in terms of how we prescribe medicines and how we treat people who are prescribed them. We have, as has been said, more non-medical prescribers—pharmacists, nurses and other allied health professionals. More people are able to prescribe in their areas of competence, but we are also building into the system medication review so that people are not just prescribed medicines but are routinely monitored to ensure that a medicine is not causing harm and that, if other medicines are added, that is taken account of.

Committee members will know and will, perhaps, have heard in other evidence that we are developing a new service in general practice around pharmacotherapy, whereby pharmacists, pharmacy technicians and some support staff are being added to general practices to help their governance in medicines prescribing—especially repeat medicines prescribing. That will bring more sense to some areas of work, because there will be reviews of medication for chronic conditions to ensure that people get the best from their medicines and not harm.

Regarding the ambition to achieve excellence in pharmaceutical care, through the GP contract we have grown that field so that up to 70 per cent of general practices now have pharmacists and technicians taking that lower-level look at prescribing and repeat prescribing. We have ambitions to allow that competency to increase and to allow pharmacists and their staff and non-medical prescribers to look at what happens through review of medicines. Can we deprescribe? Can we target patients who need medication reviews? Can we look at our polypharmacy guidance and ensure that it is being applied across the piste? We are entering a new area of prescribing that might be much more about the individual, so having such reviews will be important.

Emma Harper: We heard evidence that the cost of medicines has increased, as have costs of things such as the FreeStyle Libre device for diabetes. How are we measuring the impact of introducing diabetes tech—which has an up-front cost—in terms of a reduction in hospital admissions for type 2 diabetes complications? We have heard evidence that about £500 million a year is being spent to mitigate type 2 complications. Diabetes tech that costs a lot of money up front would improve people's glycaemic control, which would reduce admissions in the first place.

Jeane Freeman: That makes perfect sense. The difficulty in getting clear measurements takes us back to the first question that the convener asked about data collection. We need robust data collection at all levels of healthcare in order to make such comparisons. It is fair to say that we are not at that point across the country, although we are in some parts of it. For example, Fife ran a major pilot, not on what Emma Harper asked about, but in relation to type 2 diabetes and primary care and whether there was a reduction in the admissions to secondary care. However, that pilot produced very confined data. At this point, we do not have a Scotland-wide approach.

Professor Parr: What we can do upstream to stop downstream issues is a really good question. On the device that Emma Harper mentioned, that is about how patients feel about their disease and their having a choice in how they measure their blood sugar.

In the cancer programme we are looking at patient-reported outcomes. Patients are able to report quickly what they feel about their medicine if they have just been given an infusion or are at home and do not feel well. Patient-reported outcomes coming to a central place through an app will be important. Such generic approaches might be important for understanding the difference that is made to patients' lives.

This is not always just about cost effectiveness; it can also be about acceptability and, in essence, it might also stop some admissions and help patients to be more in control of the state of their disease.

Professor Strath: A very wise pharmacy academic from America came here and challenged us by saying that here in the UK we worry a lot about the cost of medicines but not enough about the consequences of medicines. That can be extrapolated from to say that we focus a lot on medicines but not on the whole pathway.

What Emma Harper described is the treatment pathway approach, which is about how medicines, medical devices and new technologies come together. As the cabinet secretary said, our ability to capture and to be able to attribute data appropriately will be key. We are trying to link that

to developments around the national digital platform.

There was a question earlier about how we make sure all the parts are aligned. Our HEPMA oversight group is co-chaired by one of the clinical advisers to the NHS Education for Scotland digital service. We made that link straight away: we think about what data can come from HEPMA, what data locks into national digital platforms—it is a bit like plug and play—and how we can bring in primary care data. We definitely have the building blocks. The size of Scotland means that we should be able to get traction and be able to establish that and roll it out quite quickly. We will probably want to focus on specific areas initially in order to gain experience, then we will think about how we spread that out.

Emma Harper: For transparency, I should mention that I am a user of an Abbott FreeStyle Libre device—I am one of those digital users.

12:15

The Convener: That is noted.

Is the new medicines fund that you have mentioned a couple of times providing the funding that is required to cover the rare and end-of-life condition medicines that health boards use? If not, are they covered beyond the funding in the NMF?

Jeane Freeman: As you know, we made a commitment—which we continue to honour—to put all the money that returns to us from VPAS into the new medicines fund, for the reasons that Alison Strath has outlined. My suspicion is that, in truth, the fund will never be big enough, because pharmaceutical companies will continue to introduce new medicines that people will want to access.

As precision medicine develops and we understand it better, there is a requirement for us and others including the SMC—which is actively considering what precision medicine might mean for its decision-making processes and what it looks for—to consider what we expect in terms of medicines coming on to the market. We will need to consider how we use the negotiations on price and discussions with pharmaceutical companies and colleagues elsewhere in the UK, which we mentioned earlier, and we will need to consider what precision medicine means for our approach to funding for medicines across our NHS. The new medicines fund is vital, but we need to parallel the work that the SMC is doing in considering its processes in anticipation of precision medicine and coming innovations. We need to consider how we fund and whether we should alter our approach in the light of innovative and important developments for patients.

Brian Whittle: You mentioned in your opening statement that non-medical interventions should become more important. The committee has discussed that many times; I think that there is agreement across the board that we need to go in that direction. However, we still have a system that by default medicalises problems when other interventions might result in better outcomes. Given that we agree that we want to integrate social prescribing more into our medical system, how practically can we do that on a national basis?

Jeane Freeman: I will say a couple of things on that, to which I know Rose Marie Parr will want to add.

We already have examples in our system of very effective use of social prescribing alongside medical intervention. You have heard from me previously about the East Kilbride example on hypertension. We have other examples.

There are two opportunities to move forward on the issue. One is through the pharmacotherapy service that Rose Marie Parr talked about, which involves conversations between pharmacists, or pharmacy technicians, and patients who are on many medicines, about which ones feel effective to them. A pharmacist might ask whether the pink pill that the person has been taking for the past two years has made any difference, and the answer might be that it has not, so they decide to stop using it for a couple of months, after which the person can choose to go back on it.

An important point about those conversations is that we are seeing evidence that people find it easier to be honest with the pharmacist about whether long-term medicines are working for them than with the doctor who prescribed the medicines. If you think about the psychology of that, it makes sense. The pharmacist then has the opportunity, through discussions with the GP, to introduce social prescribing, which could be more activity, being in a lunch club or whatever. It is about more than activity, as Brian Whittle and I have discussed previously.

We also have an opportunity to use community link workers. We need to ensure that everyone in a general practice—the pharmacist, the GPs, the advanced nurse practitioners and practice nurses—knows about all the opportunities in the community that people can be pointed towards and helped to join; for example, book clubs, walking football groups, walking groups and lunch clubs.

It is not straightforward, but we need—I come back to an earlier conversation that I had with Brian Whittle—to think about how we pull that together at national level in a way that does not dampen the important local initiatives that are vital

to social prescribing. We need to consider how we can make people aware of all the options, and what more we can do to encourage our prescribers—pharmacists or GPs—to look at the evidence and find out what is possible in their community for their patient cohort.

As the committee knows, my colleague Joe FitzPatrick is giving significant thought to those areas. We cannot continue just to talk about the value of social prescribing, as Brian Whittle has said many times, or deal just in examples; we need to find a way to actively promote social prescribing in a way that is practicable for the prescribers.

Professor Parr: Absolutely.

If our deputy CMO was here, I am sure that he would want to speak about realistic medicine and shared decision making, whereby the prescriber and the patient come together to make decisions, and the patient might decide not to take a medicine that they have been told about, because of reason X, Y or Z. People understand that the end value of medicines is a big part of how we look at prescribing and reducing harm.

We have examples of where that approach can work. Antimicrobial resistance is an area in relation to which people understand the need not to overuse antibiotics—an illness might be viral, for example—but might still feel that they need a prescription. We need to think about how we can lower that need and we need to provide education and training on that.

There have been interventions on the use of antibiotics that have worked. In the past few years, there has been a significant decrease—maybe more than 10 per cent—in antibiotics prescribing. There is a mindset in society such that there is a pill for every ill, which we must try to push back on. Lifestyle interventions are difficult and writing a prescription can be easy, so we need to think about how choices are made.

Brian Whittle: The cabinet secretary talked about pointing people in the right direction, but I would say that they need to be led in the right direction. There is a nuance, there.

With my question, I was getting at the fact that we need a healthcare system that carries local community information and can easily access local assets. That brings us back to the national digital platform that the Government is putting together, which is a community programme at national level, for want of a better expression.

How do we get to a point at which GPs, pharmacists and AHPs—we all know of great examples—can have conversations with patients with a view to understanding their interests and marrying those with what is available in the community? If we are to be successful, that is what we must do, difficult though it will be.

Jeane Freeman: I completely agree with you—that is what we must do. It sounds straightforward, but it is not.

There are practical steps, some of which we have touched on, that must be taken. A national drive is needed that allows local initiatives and does not kill them off by insisting that provision must look the same everywhere.

Mindset is another aspect: Rose Marie Parr mentioned that we need to move away from thinking that what we will get from our GP or pharmacist is a bottle of tablets or an injection. We need to help people to understand that even though they might not get those, they will still have been treated. We need to shift our mindset so that we see social prescribing as being at least of equal value to the prescription of medicines. Sometimes there will be a combination of social and medical prescription, and sometimes there will just be one of them.

The other side of that is the mindset of prescribers. That will come, in part, from phase 1 of the GP contract and introduction of the multidisciplinary team, which is partly designed to give the GP more time to have those conversations, but also introduces the pharmacotherapy service to assist them. The GPs will use anticipatory care planning, by which they can have those conversations with you, me or anyone. Many general practices do that. They have, arguably, waited until people are older before having such conversations, but anticipatory care planning provides the opportunity to have a conversation with any patient about what matters to them. We use the “What matters to you?” approach in hospitals, and anticipatory care planning is what that looks like in general practices.

I am sure that the committee has heard from Carey Lunan of the Royal College of General Practitioners, who is a huge advocate for anticipatory care planning, and did a lot of work for us on rolling it out across practices. We have been speaking to her again about how we can refresh that work so that anticipatory care planning is seen as an opportunity to have conversations about patients’ care—in particular, those who have more than one condition—so that there is shared decision making into which GPs can feed social prescribing, as well as pills.

Alpana Mair (Scottish Government): I will pick up and comment on what the cabinet secretary said. As part of a medicines review for people with—or who present with—multiple morbidities, we have introduced a seven-step process, the first step of which is to ask, “What matters to you?”

That approach allows the GP and the patient to discuss what is important to the patient and whether they can address conditions through their lifestyle. Before prescribing, a GP or a non-medical prescriber has the conversation with the patient and gets them to ask what they would do rather than take a tablet.

Alongside that process, there are pictorial shared patient decision tools that can be part of the conversation about weighing up the benefits of a medicine, because a medicine might do the patient more harm than good. The process to allow such conversations is in place and has been agreed by clinicians from medical, nursing and pharmacy backgrounds across primary and secondary care.

Miles Briggs (Lothian) (Con): Good afternoon to the panel. I want to ask a few questions about the pharmacy contract. What plans does the Government have to change the contract to create more incentives to drive better pharmaceutical care? Has any consideration been given to the benefit of negotiating the GP contract and the pharmacy contract around the same time?

Professor Parr: I will start; Bryan Lamb might want to come in on the back of what I say.

Members might or might not be aware that we negotiate the community pharmacy contract annually. This year, we have managed to have some stability in the area and, looking forward, the cabinet secretary has rightly been able to progress a three-year deal.

Generally, without going into the detail of the contract—we do not have enough time to do that—it is quite a complicated one in many ways. It is not where we would start if we had a blank sheet of paper. However, there are caveats in respect of where we are trying to progress to. “Achieving excellence in pharmaceutical care: a strategy for Scotland” definitely gives a policy perspective. We want community pharmacists to make a wider range of patient-focused interventions and come away from supply dispensing, although not completely, to perhaps look at other ways to do that and be much more up front with the patient in talking about their medicines and trying to reduce some of the harm that can happen.

There are a couple of streams to that approach. One is introducing the pharmacy first service, which will allow pharmacists to treat patients quite differently across the piste. Our population in Scotland will be eligible to go in and talk to a pharmacist about their care or perhaps their limiting symptom and get some advice. First, there would be advice; secondly, there would be self-care; and then there would potentially be treatment or referral. That will be a very different way of working, and our remuneration model has changed on the back of that. Pharmacy first is important for those reasons.

It is also about a mindset change for pharmacists. They have done quite a lot of work around that in the past few months, and I think that they have embraced the challenge. It is perhaps a much more satisfying job to use your skills and competencies to talk to a patient about their medicines rather than to do dispensing and supply work.

12:30

The other area in which we are making a push is long-term conditions. We have refreshed the medicines care and review service. For me, that is key to allowing pharmacists and their staff to look at the serial and repeat prescribing that can come from the general practice into primary care. That is the right place to be on medicines, because they are the people who are able to refer and do those medication reviews in a better way.

We have had to turn our remuneration model around, because it was really fiddly. We are trying to take the focus away from drug margins and tariffs and on to mapping more money into services. A more guaranteed global sum will allow us to pay for pharmacy first and a more enhanced medicines care and review service, so that pharmacists can do things that we think that they should be doing.

Bryan Lamb might be able to expand on that.

Bryan Lamb (Scottish Government): I cannot really add to what Rose Marie Parr has said. We are changing the way that we contract with community pharmacies on the services that they deliver. It is about shifting the model from reimbursement for the dispensing of medicines to remunerating for the pharmaceutical care that pharmacies deliver. The chronic medication service and the new NHS pharmacy first service will be key to that.

Miles Briggs: One of the concerns that has been put to the committee throughout our inquiry has been around the workforce and the destabilisation that we have seen. Recently, I visited a pharmacy in which, because of the lack of locums in Lothian, the pharmacist was finding it difficult to plan to attend her own wedding.

What sort of work is being undertaken on future proofing the workforce, given that we are seeing professionals moving from community pharmacy into NHS and GP settings? What assessment has been made of the workforce survey that took place last year?

Bryan Lamb: The workforce challenges are not exclusive to community pharmacy; we know that

there are workforce challenges across the entire NHS. As part of the three-year agreement that we have entered into with Community Pharmacy Scotland, we are looking to introduce a new independent prescribing career pathway as well as a foundation programme, which is about encouraging people to come back into community pharmacy to practise. They will be able to maximise not only their patient interaction skills but their medicines knowledge, and they will be able to provide patients with long-term treatment. That is a key change in how we are bringing people into the network to sustain community pharmacy.

Part of it is about acknowledging those people who are currently in community pharmacies and delivering, whether in independent prescribing clinics or walk-in clinics for common clinical conditions. There is recognition in the three-year deal that has recently been agreed that we will look to reward and incentivise, and that we will encourage contractors to offer better conditions that will be more comparable with what is offered in other areas of the healthcare system.

Professor Parr: On the workforce, we understand that the utilisation of pharmacists is growing, and we have put more money into pre-registration training. We are talking to our schools of pharmacy and the Scottish Funding Council about increasing the number of places in schools of pharmacy.

You are right: we have not quite got the models right across the piste. We need to look at automation and the skills mix. Perhaps technicians or assistants need to do some of the jobs that, 10 years ago, I would have done myself. How we get the skills mix right is an issue.

Flexible working is another thing that can help with workforce issues. We see pharmacists wanting to work across the piste. They might want to work a few days in community pharmacy, to have that patient contact, and work a few days in a general practice, to look at the prescribing aspect.

Going forward, we need to be flexible. That will be quite new to us.

The Convener: I know that the Scottish Government is working on a single national formulary, but we heard evidence that that should be in addition to, rather than in place of, the local formularies. Is that the Government's view? If so, how would best practice from the different formularies get rolled out or brought into the domain of the national formulary?

Professor Strath: We are developing our work towards a single national formulary from the bottom up, and we are working through area drug and therapeutics committees in individual boards. The most important thing is that clinicians have ownership of the formulary, which ensures that we have better adherence to prescribing in it. We have started to do some work in Lothian to test a platform that we have built and look at the local engagement processes so that we can think about how we move to regional convergence and then a national system.

That links in nicely with the work that we are doing around hospital electronic prescribing. We heard about the north region working collectively to implement HEPMA. One of the key things for the success of that work will be having a standard drug dictionary that people use.

For me, the point about the formulary is that we are thinking about how medicines sit in the treatment care pathways. There is a need for us to continue to ensure, as the cabinet secretary has mentioned, that there is flexibility where there is a need for that. We need a national solution, but we must ensure that there is still flexibility to allow things to work around a local system where that is needed. Focusing on clinical pathways and where the medicine sits in the pathway is the key to doing that. That would probably allow us to think about social prescribing as well as the medicines.

Emma Harper: I have a couple of questions about online pharmacies and online prescribing. We have taken evidence on concerns about online pharmacies having an impact on community pharmacies. Our briefing says:

> "Entry into the community pharmacy market and the ability to dispense NHS prescriptions is controlled by each NHS board."

What impact will online pharmacies have on our community pharmacy network? We have heard evidence that we want our community pharmacies to help to support medicines and medicine prescribing.

Jeane Freeman: I would be very concerned if there were to be a significant impact on community pharmacy. Everything that we have heard this morning, and the launch of pharmacy first, which is a major and exciting development, is linked to shifting the balance of care. Rose Marie Parr might have a bit more to say about this, but we would have some concern if we were seeing significant evidence of online prescribing having an impact on community pharmacy.

Professor Parr: I agree. There is a place for things online but, in some ways, medicines are not such a commodity. We want pharmacists to be there to talk about advice and treatment and to individualise medication. For our pharmacy first service, there is a principle, which is that we do not expect it to be given online—we want the pharmacists to be there to treat patients.

Our community pharmacy network of 1,257 pharmacies across Scotland is important because

it has social capital. It is not just about medicines—many patients visit their community pharmacy and pharmacists see many different patients across the week, for many different reasons. There is value in the fact that people can access their high street pharmacy, whether that is for public health, needle exchange or methadone. That social capital is very important, too, and it needs a physical presence.

Emma Harper: This might be a question for another day, but there are now online GPs. That is an additional concern, which it is probably worth us exploring further down the line.

With the advent of online pharmacies, is there any point in controlling entry on to the pharmaceutical list any more? How do we see that market working?

Professor Parr: There is a cross-Great Britain regulator that has its eye on online pharmacies and how they could potentially be abused; the regulator is considering how they could be regulated. There are some regulatory issues.

Bryan Lamb: In order to provide pharmaceutical care in Scotland, pharmacists have to apply to an individual health board to be added to its pharmaceutical list. A consultation must take place between all the parties—the community, the board and the applicant—and there must be a need and a desire for the services. It is not just about the dispensing of medicines, it is about the care and services that pharmacists provide to a community. The effect of the rise of online pharmacies is somewhat mitigated but, as Rose Marie Parr mentioned, the regulator will look at the area to ensure safety.

Emma Harper: I move on to questions about waste. We have heard a lot about medicines waste and the need to reduce it. Some of the evidence that we got was extrapolated from information from England. What can we do to improve our understanding of where waste occurs and how do we tackle it?

Professor Parr: To be brief, as the cabinet secretary said in her opening remarks, not all waste is avoidable. In some areas, the prescribing is correct, but the medicine is no longer used. We have systems to try and reduce waste as much as possible.

I will talk briefly about care homes. The committee might have heard about so-called overprescribing in care homes and how we reduce that. I hope that the committee has had evidence from NHS Tayside which, working with the Care Inspectorate, has good protocols to reduce medicines waste in care homes. NHS Tayside has managed to do that through protocol-driven governance, and we want to make sure that all other health boards adopt that type of approach. The discussion could go on for another hour, because waste is not an easy subject but we need to have effective prescribing guidelines in place. We can bring down prescribing numbers, but there are other aspects to reducing waste.

The Convener: Thank you. Although it is an important topic, there is no appetite for another hour of discussion on medicines waste. As we compile our report, we might come back with further queries. I thank the cabinet secretary and her officials for their evidence this morning.

Subordinate Legislation

National Health Service Superannuation and Pension Schemes (Miscellaneous Amendments) (Scotland) Regulations 2020 (SSI 2020/30)

12:42

The Convener: Item 2 is consideration of subordinate legislation. Colleagues are aware that the regulations are simply an uprating in the level of funding to account for inflation. Do members have any comments on those regulations?

Sandra White: Annex A of the clerk's note says that NHS employees and employers, the Scottish Government and UK Government departments were consulted but that

"No responses to the consultation were received."

The instrument might be a good thing, but I wanted to point that out.

I also wonder whether we will get an update on what is said in annex B on page 8 under "Consultation". It says:

"it is noted that the structure to apply for member contributions is still under active discussion amongst Scottish Ministers, the Scheme Advisory Board and HM Treasury".

It says that an assessment of

"whether the proposals are likely to achieve the required yield of 9.8% of pay over the period from 1 April 2020 to 31 March 2021, as required by HM Treasury ... shows that the yield is expected to be around 0.1% to 0.2% below the required yield of 9.8%."

There is uncertainty there. You asked us for comments; I do not want to delay the instrument, because it is about a rise and a lot of people will lose out if they do not get it. However, there is no agreement yet and the change is happening next month. Can we ask for clarification on that, or will that delay it for a while? Has there been no consultation or am I reading it wrongly?

The Convener: These matters are under constant negotiation and I am not aware of any substantive impact. That is also the view of the clerks.

12:45

Sandra White: I just wanted to point out that the change is due to happen next month but no agreement has been reached. However, I do not want to delay the instrument. I am just being a pest.

Brian Whittle: You do it so well.

Sandra White: I know that I do.—[*Laughter*.]

The Convener: Far be it from me to reach that conclusion. Having noted the comments that Sandra White has made, are we agreed to make no recommendations on the regulations?

Members *indicated agreement.*

Public Health etc (Scotland) Act 2008 (Notifiable Diseases and Notifiable Organisms) Amendment Regulations 2020 (SSI 2020/51)

The Convener: The Delegated Powers and Law Reform Committee has noted that the regulations, which relate to coronavirus, came into effect the day after they were laid. While drawing our attention to that fact, having concluded that the Government was reasonable to act as it did, the committee made no recommendation. As members have no comments, are we agreed to make no recommendations on the regulations?

Members *indicated agreement.*

12:46

Meeting continued in private until 12:56.

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