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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 29 April 2014

Session 4

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HEALTH AND SPORT COMMITTEE
13th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Andrew Buist (British Medical Association)
Jackson Carlaw (West Scotland) (Con) (Committee Substitute)
Professor John Cromarty (Royal Pharmaceutical Society in Scotland)
Martin Green (Community Pharmacy Scotland)
Professor Stewart Irvine (NHS Education for Scotland)
Professor Norman Lannigan (NHS Greater Glasgow and Clyde)
Dr Miles Mack (Royal College of General Practitioners)
Alpana Mair (Scottish Government)
Michael Matheson (Minister for Public Health)
David Pfleger (NHS Grampian)
Michael Pratt (NHS Scotland Directors of Pharmacy Group)
Dennis Robertson (Aberdeenshire West) (SNP) (Committee Substitute)
Professor Bill Scott (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health and Sport Committee

Tuesday 29 April 2014

[The Convener *opened the meeting at 09:45*]

Subordinate Legislation

The Convener (Duncan McNeil): Good morning and welcome to the 13th meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone in the room to switch off their mobile phones, BlackBerrys and so on, as they can interfere with the sound system and disrupt the committee. Some members and officials are using tablet devices instead of hard copies of their papers.

We have apologies from Nanette Milne and Richard Lyle. Once again, Jackson Carlaw joins us as committee substitute for the Conservative Party and Dennis Robertson joins us as committee substitute for the Scottish National Party. I welcome them both.

Health Professions Council (Registration and Fees) (Amendment) Rules 2013 Order of Council 2014 (SI 2014/532)

The Convener: The first item of business is consideration of four negative Scottish statutory instruments.

No motion to annul the first instrument has been lodged. The Delegated Powers and Law Reform Committee has drawn the attention of the Parliament to the instrument—the details are in members' papers. As there are no comments from members, do we agree to make no recommendation on the instrument?

Members *indicated agreement.*

National Health Service (Charges to Overseas Visitors) (Scotland) (Amendment) Regulations 2014 (SSI 2014/70)

The Convener: No motion to annul the regulations has been lodged. The Delegated Powers and Law Reform Committee has drawn the attention of the Parliament to the regulations—again, the details are in our papers. As there are no comments from members, do we agree to make no recommendation on the regulations?

Members *indicated agreement.*

National Health Service (Physiotherapist, Podiatrist or Chiropodist Independent Prescribers) (Miscellaneous Amendments) (Scotland) Regulations 2014 (SSI 2014/73)

The Convener: No motion to annul the regulations has been lodged, and the Delegated Powers and Law Reform Committee has made no comment on them. As there are no comments from members, do we agree to make no recommendation on the regulations?

Members *indicated agreement.*

Glasgow Commonwealth Games Act 2008 (Duration of Urgent Traffic Regulation Measures) Order 2014 (SSI 2014/92)

The Convener: The Delegated Powers and Law Reform Committee has made no comment on the order. As there are no comments from members, do we agree to make no recommendation on the order?

Members *indicated agreement.*

Pharmaceutical Care Action Plan

09:48

The Convener: Item 2 is an evidence-taking session on the Scottish Government's pharmaceutical care action plan, "Prescription for Excellence". I welcome our first panel, who are from the Scottish Government's finance, e-health and pharmaceuticals directorate. Professor Bill Scott is the chief pharmaceutical officer and Alpana Mair is the deputy chief pharmaceutical officer.

I invite Professor Scott to make some opening remarks.

Professor Bill Scott (Scottish Government): I thank the committee for inviting us to talk about our action plan and vision for pharmaceutical care. "Prescription for Excellence" builds on the direction of travel of our progressive and developing policy landscape for high-quality and sustainable health and social care and on the comprehensive year-long study and review of national health service pharmaceutical care that Dr Hamish Wilson and Professor Nick Barber undertook, which concluded in autumn 2012.

The study by Wilson and Barber was underpinned by a wide-ranging and lengthy engagement and evidence-gathering exercise. It is important to note that "Prescription for Excellence" is predicated on the route map to the Scottish Government's 2020 vision and its quality strategy ambitions. It plays to the strengths of pharmacists as experts in the therapeutic use of medicines and their potential contribution to and integration into health and social care teams.

I emphasise that pharmaceutical care and our vision and action plan transcend what we traditionally associate with the services that are available from our local high street pharmacies and the common perceptions of what a pharmacist is and does. That goes beyond the individual pharmacist's practice. It involves new and innovative models of care and pharmacy practice that will be crucial to how we address the healthcare challenges that we will face as we go further into the 21st century. It involves a different approach to practice that requires pharmacists to work in partnership with patients and other health and social care professionals.

The cabinet secretary has emphasised the continuing and important role of pharmacists who are located in our communities and high streets across Scotland—quite so; they are the first port of call in our healthcare system. Their future relationship with other local health and social care providers will be important. That is crucial to service planning, particularly in remote and rural areas and in deprived communities.

We should be proud that, over the years, NHS pharmaceutical care in Scotland has established a well-earned United Kingdom and international reputation for innovative models of care. "Prescription for Excellence" is already following in that vein; others in the UK and abroad are following developments closely.

"Prescription for Excellence" keeps Scotland at the forefront of innovation and high-quality pharmaceutical care and will make a significant contribution to our shared goal of having world-leading healthcare. Most important, it puts the patient at the centre of our health systems.

Aileen McLeod (South Scotland) (SNP): I thank Professor Bill Scott and Alpana Mair for coming along. A number of those who have submitted evidence have discussed the policy context to the strategy and action plan and have referred to the previous pharmaceutical strategy—"The Right Medicine"—from 2002. We have also had the Wilson and Barber review, which was published last August. What benefits did the previous strategy bring to the delivery of pharmaceutical care services, and how will the new strategy build on that, particularly in the light of the 2020 route map?

Professor Scott: Before we had "The Right Medicine", pharmacies concentrated mainly on the dispensing process. With "The Right Medicine", we brought into the pharmacy contract the chronic medication service, our minor ailment service and public health services.

Pharmacies have started to build into services that patients register for and they are starting to demonstrate a great deal of success—particularly in relation to the minor ailment service, for which patients can register. That service was brought in under the auspices of social justice; it helps people who are of low income, who have young families or who are 60 and over.

The chronic medication service—patients do not particularly like the word "chronic", so we will need to change the wording a bit—is there to help pharmacists identify patients who need more help to understand and take their medicines. We have added other areas, such as the identification of high-risk medicines, so that service has started the march along the pharmaceutical care route.

Aileen McLeod: The action plan and the review itself make a lot of recommendations. How is that work being taken forward with stakeholders? How is the Government engaging with stakeholders to take forward the work of the action plan?

Professor Scott: Wilson and Barber had a number of meetings with all stakeholders. That

was when they made the recommendations, which we then looked at. At that time, the health and social care integration work was also going on in the department so we wanted to blend together the recommendations with that work. We will now start to take forward the work—with stakeholders—that will help to deliver the actions.

Aileen McLeod: Can you talk us through who sits on the steering board and how often the board will meet to take forward the work programme?

Professor Scott: Yes. The steering board is a high-level board and the people on it from the NHS and the Scottish Government are involved in delivering other parts of the health and social care strategy. Alpana Mair can give more details.

Alpana Mair (Scottish Government): Most of the directors from within the health and social care management team are on the steering board, to ensure that the work that is being delivered on "Prescription for Excellence"—which, as Aileen McLeod rightly pointed out, cuts across the 2020 route map—delivers in primary care, health and social care integration and scheduled social care. Those directors have been included on the board to ensure that work packages within "Prescription for Excellence" are incorporated in their work plans. Indeed, at the first steering board meeting, members made a real commitment to look at their work plans to work out how we can integrate pharmacy into other areas of healthcare delivery, to ensure that we have a patient-centred strategy.

In addition to directors from across health and social care, the board includes a medical director, who represents the group of medical directors, and a director of pharmacy, together with representatives of the Royal Pharmaceutical Society and the Royal College of General Practitioners, who are there to represent all the royal colleges. The chief social worker is also part of the steering board to ensure that we have integration across health and social care.

Alongside the steering board will sit a reference group, which will have wider stakeholder membership.

Aileen McLeod: Obviously, there will be different workstreams as well. How often will the steering board meet?

Alpana Mair: It is anticipated that the steering board will meet about three or four times a year. We had our first steering board meeting last week and we all agreed that, between steering board meetings, all the members will need to work on delivering work programmes. Our terms of reference were also agreed at that first meeting.

It is important to note that there will be a core programme management team, which will implement the work packages that are designed to deliver the action points that are addressed in "Prescription for Excellence". Relevant members, including stakeholders, will be part of the workstreams, and the steering board has been asked to consider that work and who will be involved in it.

Aileen McLeod: Okay. Thank you.

10:00

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am hugely supportive of the direction of travel that we have been taking in Scotland, which is quite different from the one that has been taken in England. It is critical that pharmacists—and, indeed, optometrists and others—are full partners in the health service, but there are problems to do with the fact that they are not direct employees of the health service. Although general practitioners are independent contractors, we have a pretty firm contract with them. Under the pharmacy contract, it is proposed that every patient will have a named pharmacist and that every pharmacist will be a prescriber. That is highly aspirational and challenging, which I welcome.

Could you provide a little more detail on how you will get that in place, given that many community pharmacies are not in individual ownership? Many of them are owned by big multiples. Private firms such as Boots and Lloyds Pharmacy have an ethos that overlaps ours, but which is not exactly the same as ours. In addition, pharmacists move around. I can foresee many problems, so could you elaborate on how you see things developing?

Professor Scott: Certainly.

As we all know, NHS Scotland is a free, truly public service that is built on co-operation and collaboration. The retail sector, which community pharmacy is classed as belonging to, is about competition and footfall. In order to provide patient-centred clinical care, we must change behaviours. It will still be possible for pharmacies to be competitive on their sales, but pharmacists will be expected to co-operate and collaborate to deliver NHS care.

In some cases, we are looking at combining the training of the undergraduates who go through the schools of pharmacy with that of their medical colleagues. We want to encourage a culture of working together for the patient. Part of the discussions with the large companies will be about the fact that, when they provide a service for NHS Scotland, they must provide it in a way that is based on collaboration and co-operation.

Dr Simpson: I very much welcome that. I think that that is the ethos that all four parties in

Scotland support. It is good that we have an agreement on the general direction of travel.

However, I still have concerns about some practical issues. The patient is still handed paper prescriptions and, as far as I know, pharmacists do not have access to emergency care records. Do you have a separate workstream on the information management and technology side of things?

Ultimately, we should put an end to paper prescriptions. We talk all the time about having patient-centred systems, but they often tend to be producer oriented. We should ensure that the patient has control over their own data by allowing them to give the pharmacist access to their emergency care record, which they could do by putting in a code, as they do with their bank accounts—the code could be the last four digits of their community health index number. I am sorry, convener—I am suggesting solutions; I should not.

The principle is there. I have worries that, if we do not have genuine patient control, there will be issues with confidentiality, privacy and so on.

Professor Scott: I totally agree with you. We do not want the patient to be a victim; the patient must be a partner in the process. We have put a lot of effort into electronic prescribing. Every general practitioner and every community pharmacy in Scotland are now linked electronically, and patients will be able to get their prescription transmitted to the pharmacy as part of the chronic medication service.

We met our target to get everyone interconnected by December 2013. Our target this year is to ensure that GPs become familiar with the repeat prescribing system. We have set a target to have that work well under way by December 2014. Some pharmacies are now receiving electronic prescriptions.

We will have to get rid of the paper prescription, and we will have to find ways in which prescriptions can be signed, but I do not think that that will be a problem in the end. As you rightly say, the information must be under the patient's control.

Dr Simpson: Thank you for that. I might wish to come back on that subject later, convener.

The Convener: I might consider letting you do so.

Bob Doris has a supplementary question about the named pharmacist.

Bob Doris (Glasgow) (SNP): Like Richard Simpson, I am drawn to the idea of a named pharmacist, as well as the pharmacies being listed with NHS boards and that information being held and used to advance community pharmacies. I noticed that Community Pharmacy Scotland, which will give evidence later, seems to have some kind of nervousness around that, but its representatives will be able to put their views on the record.

I am content, as long as the system is inclusive and any individual patient can still walk into any community pharmacy on the high street and get service if they wish to do so. Will the system still be inclusive? If that reassurance can be given, I think that it is good that the individual pharmacist-patient relationship will be built up and strengthened. With that caveat, I welcome the idea. Can you give that reassurance?

Professor Scott: Yes. We included the named pharmacist because, when Wilson and Barber talked to the patients alliance—the Health and Social Care Alliance Scotland—and other patient groups, they found that it was the patients who wanted continuity.

At present, people register with the chronic medication service and they register with a named pharmacist. If someone wants to take their prescription elsewhere or to change their pharmacy, or if they have an acute prescription or wish to purchase a medicine, they can do that anywhere.

Bob Doris: That is fine. I will leave it at that for now. I might want to ask Community Pharmacy Scotland for its views on the matter in the round-table session.

The Convener: I will pick up on some of the themes that the deputy convener raised. You mentioned that the steering board has a strategic role but that there is not a role for the community pharmacists, who are not on that board. Why is that?

Alpana Mair: Community pharmacists are part of a group of many stakeholders. The vision and action plan is about all pharmacists working across all sectors. The directors of pharmacy are on the board in order to provide input, as is the professional body. Other groups such as community pharmacists will be represented through the reference group, so that they can provide their views and opinions. The stakeholders told us that they want to be a sounding board and to provide input. The chairs of the reference group will also sit on the steering board, so they will have a direct route into the steering board for raising issues that they may have.

Community pharmacists will also be part of the relevant working groups. There are work packages that need progressing in relation to "Prescription for Excellence" commitments, and community pharmacists will be part of the working groups that will address the delivery of some of those areas of work. They will be included where they are needed

in relation to those work packages, and they will be part of the reference group.

Professor Scott: We have had a number of calls to be on the steering group, from the unions and from other trade bodies. The role of the steering board is to ensure that, throughout the Scottish Government and the NHS, people are taking forward the commitments in "Prescription for Excellence" and also delivering the 2020 vision. The reference group is there as a critical friend, but it is also inputting into the steering board and the core management implementation team.

The Convener: I do not know whether that answers the question. Some members of the committee have already been vocal on this point. It seems as if community pharmacists, despite their continuing role in delivery, feel excluded from the strategic body.

Professor Scott: They are not being excluded, because they will form part of the working groups.

The Convener: They will sit on the working groups with other trade bodies, trade unions and so on. That hierarchy seems a bit strange to me, given the community pharmacists' role in delivering much of the strategy, as they do not have a say at that level.

Professor Scott: They will be delivering it, as will all the other pharmacists and other healthcare workers. The steering board is there to look at policy as it changes and to ensure that "Prescription for Excellence" is taken forward.

The Convener: How many people are registered with pharmacists for the chronic medication service?

Professor Scott: That is a good question. I have the numbers somewhere.

Dr Simpson: I asked a parliamentary question about that a few weeks ago, so we should have some figures soon.

Professor Scott: So you can tell me.

Dr Simpson: The answer should be just about to come out.

Professor Scott: I shall look that up for you.

The Convener: There are hundreds of thousands of people directly linked with those pharmacists, are there not?

Professor Scott: Yes.

The Convener: Individual pharmacists or community pharmacists?

Professor Scott: They are registered with all community pharmacists.

The Convener: Hundreds of thousands of people are registered with those community pharmacists?

Professor Scott: Yes. There are 380,454.

The Convener: Does that not give them a seat at the steering board?

Professor Scott: In the sense that the steering board is about overall Government policy, no.

The Convener: We shall probably hear more about that later.

Rhoda Grant (Highlands and Islands) (Lab): As you will be aware, a lot of community consultation work is going on to allow communities to have a say about opening pharmacies. However, that consultation does nothing to address the lack of pharmaceutical services in remote and rural areas or to allow people to access those services without destabilising existing GP services. Is any work being done on that?

Professor Scott: As you know, we put out a consultation, which is now being looked at in the department. The results of that consultation and the department's response will be out later. We have been talking to an island board that is keen to look at the role of the pharmacist in working with dispensing doctors, and it is building up a programme for a project so that we can test pharmaceutical care in a dispensing doctor area where patients will have access to a pharmacist.

Rhoda Grant: When do you expect that project to commence?

10:15

Professor Scott: The board is now working on it. The medical and administrative staff whom we met were very supportive. We expect that we will be able to go public on the project after the Government response to the consultation comes out.

Rhoda Grant: So when the Government responds to the consultation, you hope that it will announce the pilot scheme. I think that I know which health board it is—I have been pushing the island boards, which are all in my area—but can you confirm that and say what the timeframe is for a possible pilot? People are missing out on services. While the conflict between pharmaceutical services and GP services continues, people will not be receptive to pharmaceutical services and will thereby miss out.

Professor Scott: I would like to tell you which board it is, but we are keeping the issue quite close. I rather hope that, once I have cleared the matter with the board, it will be in the public domain.

Rhoda Grant: Did you say that the announcement will coincide with the announcement on the consultation?

Professor Scott: It will be very near it. We have asked the board to send in a project plan and some costings. Once we get a look at that, we will be able to move on.

Rhoda Grant: Will the project include direct patient interaction with pharmaceutical services?

Professor Scott: It will include the pharmacist having a case load of patients who are, in the doctor's opinion, on complex medicines and things like that. It will be similar to the pharmaceutical care that we want to offer in other areas.

Rhoda Grant: My concern about the lack of pharmaceutical services in such areas is not so much about the complex care that pharmacists offer, because my understanding is that GPs can currently access that through their health board and can have a review of medications. I am worried about Joe Bloggs walking down the street who has a minor ailment and who wants advice on it but who maybe does not have the time or the energy to go to their GP and wait for an appointment. People ignore minor ailments because there is no service available to them. I know that it is important that GPs have access to pharmaceutical services, but it is equally important that individuals have access to them, too.

Professor Scott: I will take that back, then. In essence, the first thing that we want is to have the pharmacist, as the person with pharmaceutical expertise, to engage with local doctors. We are not considering minor ailments at this stage.

Gil Paterson (Clydebank and Milngavie) (SNP): I have a question about public awareness. Professor Barber and Dr Wilson highlighted in their report the need to engage with the public to inform them and keep them up to speed on the relevance of the process. That is a big job. What action is the Government taking to inform the public and get them on board?

Professor Scott: That is a good question. I ask Alpana Mair if she would care to answer it.

Alpana Mair: Through the alliance, we had a facilitated day with key patient groups at which we shared with them the same presentation that we have shared with key stakeholders around "Prescription for Excellence". Ian Welsh is on the steering board to ensure that we engage with patients and bring the patient voice to the table. We expect that Irene Oldfather, who leads in the alliance, will be part of the reference group.

There is an important piece of work going forward. The message that we heard from the public groups was that they wanted to work with us to raise awareness among patient groups and patients of the role of the pharmacists' input into their care, particularly around complex medicines, and the direction of travel of that role. We have agreed with the alliance that we will work with it and that we will set up a memorandum of understanding.

A patient liaison worker will work with us to undertake pieces of work with different patient groups across Scotland. That will be a bit like doing a think piece, as has been done with health and social care integration, so that the liaison worker can help to produce literature that can help patients to understand the role that pharmacists can play. We think that that is crucial, because the patients tell us that they need to know more, but we need to tell a wider audience more about the role that pharmacists can have. That is a piece of work that we will start to do with the alliance, and it will work with us very closely to ensure that we deliver the key messages and take on board the patient voice at all points in our journey.

The alliance said to us clearly that it wanted to be part of the working groups. As we put together new packages of work and new ways of delivery, the patient will therefore be at the centre and will help to inform the direction of travel.

Gil Paterson: Perhaps even more important, fellow professionals would be required or encouraged to engage and help the process. Has work been done to action that with relevant fellow travellers in the area?

Professor Scott: In our work programme, those are the things that we will talk about in discussing how we engage with the public and what sort of literature we will have. The patient alliance will help us to understand what the public require.

Alpana Mair: Gil Paterson asked about engagement with fellow professionals. One thing that came from the healthcare professionals who are on the steering board was their willingness to take the vision and message out to their key professionals. Indeed, we heard from the medical director that they need to ensure that they take the message out and share it with their secondary care colleagues. They have undertaken to do that work.

We are also working with the RCGP, which will represent all the other royal colleges, and the nursing profession to ensure that we engage and work with our healthcare professionals. We also need to do that with our social care colleagues.

Gil Paterson: You have second-guessed my next question, which was about the supportive elements, whether other professionals are encouraging, and whether they are on board. You have answered that question.

The Convener: Can we look at workforce planning? How many pharmacists are there in Scotland?

Professor Scott: There are around 4,200. We want to look overall at the whole of primary care in workforce planning because, in order to move ahead as we want so that people are treated and cared for in their own home or community wherever possible, we must think about what the dynamics are for that in respect of secondary care, as well. That is because, as we acknowledge in "Prescription for Excellence", some medicines that used to be prescribed only by hospital physicians are now available in communities to patients who are still under the care of their consultants. What we want and need to do is integrate the work of the hospital pharmacy specialist with that of the community pharmacist and the GP, so that we look after patients in the best way possible.

We will investigate the overall workflow and manpower planning. We have asked NHS Education for Scotland to help us with some of that.

The Convener: Have we got too many pharmacists, or not enough? Is the number just right?

Professor Scott: That is a difficult question. We are now seeing unemployment in pharmacy, because in England—not in Scotland—a significant number of new schools of pharmacy have opened, and because, given our links with Europe, pharmacists in Europe are entitled to practise over here. We are probably at a stage at which we want to look at intake in our pharmacy schools. That is certainly going ahead in the Department of Health, down in England.

The Convener: What are you doing here? Are you just watching what is going on down there? Have you initiated a workstream on the issue?

Professor Scott: No. What we wanted to do was consider why we need pharmacists and what we use them for. That work will inform how we limit numbers in the education programme, if that is the best approach.

The Convener: That leads me to my next question, which is about the mix that we have. We have community pharmacists, clinical pharmacists and so on. Are the pharmacists in the right areas, or is there an imbalance? Are there too many in the community, for instance? What have you found in your work in the area?

Professor Scott: If we are to dispense 90 million prescriptions a year, supervise substance misuse and so on, we have to look at the whole skill mix in pharmacy, including pharmacy assistants and pharmacy technicians. As you see from the submission from CPS, the private sector regards manpower as a confidential issue. I think that we will have to say to the private sector, "If the bulk of your work comes from the NHS, we will expect to work with you and to get that information."

The Convener: Your response nearly made me go back to the steering board and why some people are not part of it.

Discussions about the workforce are not unique to pharmacy; we have had such discussions in relation to other parts of the health service. You mentioned technicians and other people. What will the pharmacy workforce look like in 10 or 20 years' time?

Professor Scott: This is why we have the work programme, of course. It could be that prescriptions for routine medicines will be dispensed not in the pharmacy but in a hub, using robotics, and that the clinical pharmacist will spend most of their time on patient-facing work. On the other members of staff who work in pharmacies, we have funded courses for what we call pharmacists' assistants. They will collect information for the pharmacist before the pharmacist engages with someone. I therefore think that things could look quite different from how they are today.

10:30

The Convener: How would the robotics work? I presume that different groups of people would be treated differently in that process. For example, would people on chronic medication get more patient-facing contact, or would contact be online?

Alpana Mair: That is one of the workstreams that we want to consider, and we will consider it fairly early on. We plan to run some pilots with health economists and our colleagues in the Scottish Government capital and facilities department, who will work on modelling. We know that some pharmacists already use robotics in their pharmacies, and we have learned lessons from them. However, we want to undertake some pilots in order to look at different models and communities and to see how the models work before we decide on one that we think is the way forward.

It is important to take the time to find out what works for patients, pharmacies and the workforce. We are proposing using robotics as a means of releasing capacity to deliver clinical care. We therefore need to do some health economic modelling—which we plan to do in the next couple of years—to gather the evidence and data that we need. Again, we very much hope that we can work with our community pharmacy colleagues across Scotland to do some of the pilot work, and that we

can work with health boards to identify suitable pilot sites and models.

The Convener: Do you have proposals on pilots to put to boards or will they help you to develop the pilots?

Professor Scott: The boards will help us to develop the pilots.

The Convener: Bob Doris has a supplementary question, as has Richard Simpson. I think that Dennis Robertson has a fresh question, but I will take the supplementaries on this theme first.

Bob Doris: Thank you, convener.

Professor Scott, I think that you would have been as well not to give a huge amount of detail in your response to an earlier question, given that we are going through a period of change and that you outlined what the pharmacy could look like in 10 or 15 years, rather than what it would look like. Ms Mair talked about a workstream and drawing in all the professionals to it. With regard to the distinction between the workstream and the steering board, I would expect to see clinical pharmacists and community pharmacists involved in the workstream. Will that be the mix?

Professor Scott: Yes.

Bob Doris: Okay. The next thing that is screaming out at me is what we have done within the NHS. Although pharmacy is not the NHS, there are contractual relationships there—or not, as the case may be—in relation to, say, workforce planning tools for nurses whereby you map out where nurses are in the community, in the acute sector, in accident and emergency, in elective surgery and in mental health, and then you come to a number that you need, and that feeds into the training.

The Convener: Question, question.

Bob Doris: I know. The convener is saying "question", but what I am trying to tease out is this: do we need a workforce management or planning tool for not just community pharmacists but all pharmacists? Can we develop that now, or do we have to wait until what the pharmacy will look like in five or 10 years is teased out more? We could develop a planning tool now that would be fit for the pharmacy today, but if pharmacy is going through a period of change, when would we expect to see the work done on that?

I am sorry, convener, for the long intro, but I think that these issues are really important if we are going to plan ahead in a professional manner.

Professor Scott: I can take that question. We have someone here from NES—you will speak to them later—which has been doing some good work with dentists on workforce planning. We have a workforce planning team within the Scottish Government and we have had early discussions with it about how pharmacy can be built into its work schedule.

Bob Doris: Okay. Just for clarification, I will ask another question at this point.

The Convener: Remember that you are just asking a supplementary question.

Bob Doris: I know.

It is not presupposed that that team will work in tandem with the workstream on pharmacy workforce planning that we expect to come from the steering board. We have to ensure that the two things work together and are not in silos.

Alpana Mair: I think that they will. That workstream will report back up to the steering board and it will link into relevant policy areas, which means the workforce group within the Scottish Government.

The other important issue that Bob Doris touched on and which others have raised is that in addition to looking at the workforce, we need to look at the needs of the population in particular localities. Many of our pharmacist colleagues in health boards—the public health pharmacists—have started to develop mapping tools so that we can identify what kind of services are required for what kind of patients. We need to build our workforce around that. Health boards have a key role in that process, so we need to work in partnership with them. We have already started to have those conversations with them and have drawn on the really good work that they are starting to produce. It is important to ensure that our workstreams dovetail.

The Convener: I put on the record again—as we do regularly at the committee—that we support and recognise the need to change the health service in all its parts in order for it to deliver effectively for the people of Scotland. We are not divided on that politically, but that does not absolve us from asking questions about whether there is clarity. If a strategy has been developed but we are not clear about the workforce that we need in order to deliver it, there is an issue. I do not know whether that is putting the cart before the horse, but that is what we are trying to get at.

Do you have a supplementary question, Richard?

Dr Simpson: My question is about safety, robotics and waste, so it is maybe a separate issue.

The Convener: We will come back to that and let Dennis Robertson ask his question now.

Dennis Robertson (Aberdeenshire West) (SNP): Given that we are keeping the patient at the centre, how close should the pharmacy

practice be to the patient? In that respect, is there a difference between urban and rural areas? Rhoda Grant mentioned remote and rural areas. Should the distance be based on population size or on location? What are your thoughts on that?

Professor Scott: Pharmacies' locations are, historically, based on market forces. We want to examine that in our planning; boards will start to look at population needs and match that with the service. That means that we will have to start to look at new ways of planning services. We currently have control of entry, which is very much driven by the market. We are asking health boards to use the planning tool to identify where the vacuum is and to make arrangements to have it filled.

Dennis Robertson: Do you envisage relocation of some pharmacy practices?

Professor Scott: Pharmacy practices can currently relocate, if it is a minor relocation, without going through any long process, but we are asking the boards to take more responsibility for where they place their services. I should also say that we imagine that all patients go to a pharmacy but, in fact, as people get older and become infirm they are more in their homes, so the question is how the pharmacist will be able to engage with them either through their carer or directly.

Dennis Robertson: That is excellent. Thank you.

Alpana Mair: We will also be looking at how we use technology. We already have good examples of how technology is used by other healthcare professionals and we want to make sure that we look at that for pharmacists, in delivering clinical care, in order to optimise the benefits for patients.

Dennis Robertson: There is also an impact on infrastructure, because some technology is not available in remote and rural areas.

Alpana Mair: That is right.

The Convener: What other barriers to innovation have you discovered and anticipate needing to overcome?

Professor Scott: Do you mean barriers to use of technology?

The Convener: I was referring to technology and the examples that others are using. I take it that there is a bit of a workforce issue in terms of getting people on board and accepting that change is necessary.

Alpana Mair: We know that NHS 24 has done key work on use of technology. We have had initial discussions with it about how we might work with it to learn the lessons that it has learnt and to look at how we can facilitate pharmacists accessing technology. It is really important that we work with NHS 24, which already has experience of implementing some of the technologies, on how we can facilitate pharmacists using technology.

Jackson Carlaw (West Scotland) (Con): I have been listening carefully—I have to say with a mounting sense that there is a lack of enthusiasm. If something has the potential to turn out to be a complete shambles and a muddle, it invariably does, in my experience. How are you going to preclude that being the outcome of what you are proposing?

Professor Scott: Since we put the document out, there has been a great deal of enthusiasm and we have been approached with offers to help us to develop models. We have to allow health boards to try some of these things out, so that we can either learn from success or stop because of failure. Sir Lewis Ritchie, who is chairing this group, will keep a very tight rein on things.

Jackson Carlaw: I am reassured by that. I am just slightly concerned, given my business background, by the multitudinous areas where it seems to me that things could go slightly astray unless a very tight grip is kept on them and there is flexibility as they progress, so that in the event that it becomes apparent that something that seemed like a lovely idea is having a negative consequence, something is done before we end up having to come back here and investigate. Whatever the general support for the principles, delivery seems to me to be quite fluid.

Professor Scott: That is exactly the conversation that was held in the first meeting of the steering group.

Dr Simpson: You mentioned robotics, which I think is part of the future. Forth Valley royal hospital in Larbert has a fantastic robotics system, which has improved interaction between the clinicians and pharmacists and has enormously reduced waste and the capital that is required for storing medicines. It has made a huge improvement in efficiency.

In a sense, although community pharmacy has multiples, it is still at the stage that general practice was at 20 years ago; it is still very much an individual shop outlet marketing all sorts of things.

As you will be aware, we also know from recent research that the error rate in GP prescribing is not insignificant. Fortunately, most of it is not serious, but nevertheless there is a fairly significant error rate.

I would like you to take us through three aspects. The first is the role of the NHS, as opposed to the private multiples, in terms of the potential for robotic prescribing and interaction with the private sector. The second is the effect on

safety and how you see that developing, with strengthening of the pharmacy role to ensure that errors are picked up and corrected. The third is what the impact on waste will be.

Behind all that, what research and monitoring will you do? We are learning as we go along. As Jackson Carlaw's question made clear, we are in a relatively fluid situation, in which new models will be tested. Unless we do really good research, audit and monitoring we could end up in a bit of a guddle, instead of developing the world-leading models that we have the potential to develop.

10:45

Professor Scott: The Wilson and Barber review had a presentation from a robotic dispensing company that has something like three or five robots that serve a huge population in Holland. We must learn from mistakes there.

The services are delivered on the NHS's behalf, so the director of pharmacy and the information technology head must have oversight to ensure that whatever we do is put through our e-health programme, for example. We have had a good relationship with that programme, which our e-pharmacy programme links into; the e-health people are involved in the e-pharmacy programme.

We are conscious that we do not want to invest in something that is a waste of money, as Jackson Carlaw suggested. We will learn from others and we will work with e-health colleagues. The work that was done with NHS Ayrshire and Arran's computer system for hospital prescribing demonstrated that the number of errors started to reduce.

Dr Simpson: Convener, could we have a note on that? That would be helpful.

Professor Scott: I will get NHS Ayrshire and Arran to give us its report.

As for the impact on waste, I do not think that any of us in the medical fraternity wants waste; we would rather have the money used for better patient care. We are looking at a number of areas in relation to waste, one of which is the Scottish therapeutics utility—STU—which is computer software that will help GPs to identify potential areas for waste; it looks at the number of prescriptions that are written and what have you.

Alpana Mair will say something about waste.

Alpana Mair: Dr Simpson talked about research. The University of York's report on the causes and costs of waste medicines identified the key point that a systems approach is needed in order to reduce waste. Central to that are proper medication reviews and work with patients to improve adherence. That is the approach that we propose to take under "Prescription for Excellence". We have built that on lessons that we have learned from work that we have done; for example, the polypharmacy work to identify patients who are on multiple medicines. We can find the interventions to reduce the number of medicines that people take, but that is a side issue; the most important issue is to improve safety and reduce harm for the patient. Those have been our key focuses in reducing inappropriate prescribing.

The research that underpinned the support for pharmacists working with GPs is illustrated by the PINCER—pharmacist-led IT-based intervention with simple feedback in reducing rates of clinically important errors in medicines management in general practices—trial. We used that as a reference when we put together "Prescription for Excellence".

As members know, Audit Scotland's report on prescribing in general practice made similar recommendations. We have taken such evidence and built on it in going forward under "Prescription for Excellence" to increase pharmacists' capacity to work with our GP colleagues, and to look at prescribing and the management of patients, so that we prevent the problem of waste and at the same time support patients, through appropriate prescribing, in adhering to appropriate medicines.

Dr Simpson: Thank you.

Colin Keir (Edinburgh Western) (SNP): I am relatively new to the committee so I want to ask a little bit more about this and get a bit of background. I am told that there are some fundamental data protection difficulties with pharmacists having access to medical records. For the novice among us, how have those difficulties been identified? Is there any resistance to change or could we see a freer flow of information in the future? How could we maintain that and keep people on board with it?

Professor Scott: There has been resistance in the past. Even in the hospital sector, it took a long time before hospital pharmacists could get access to case notes. We are all healthcare professionals who are bound by the regulator and code of ethics; you do not get a confidentiality gene when you become a healthcare professional.

At present, if a pharmacist is involving himself in a polypharmacy clinic, they will normally work in the GP surgery or practice where they can have access to case notes. However, from the evidence that has come in from others, we can see that getting access to patient information would make the whole system a lot safer. To do that, we have to get agreement from our medical colleagues and we need systems that assure the patients and give

them confidence that, if their information goes into a pharmacy, it will not end up in the head office being used for other purposes. That is the conversation that we are having and will continue to have.

Colin Keir: Thank you.

The Convener: I am interested in the Dutch model mentioned earlier that dispenses for vast amounts of people. Sometime in the future, I will go to the GP, who will give me an electronic prescription that goes to the robots and I will be able to go and pick up my prescription at a central point. Is that what will happen?

Professor Scott: That is what would happen.

The Convener: Is that what happens in Holland?

Professor Scott: I would have to check and come back to you on that.

The Convener: Is that service in-house or is it contracted out?

Professor Scott: A company provides the service.

The Convener: It is not in the health service. The company provides those services on a bigger scale.

Professor Scott: Yes. I will go back and check that with Barber and Wilson's notes.

The Convener: Have there been any calculations of the savings that such a method could mean for the health service in Scotland?

Professor Scott: We have not got those calculations, but if we do things on a larger scale using a more efficient system, it should produce savings.

The Convener: And the basic investment would be provided by the private sector when it set up the robotic system. The health service would not incur any capital costs.

Alpana Mair: We will be informed by the modelling work that we will do with the robotics. It is key to take that work into consideration because it will identify some of the issues.

In Scotland we need to take into consideration issues to do with our remote and rural communities. If we are talking about a central hub, we need to take account of transport costs, for example. It is important that we take account of the findings of the pilot work, to inform our thinking, because we must make the service relevant to the public whom we serve in Scotland. It is important that we consider the outcomes from the pilot studies.

The Convener: But the strategy is based on some thinking, is it not?

Alpana Mair: Yes.

The Convener: In cities such as Glasgow and Edinburgh there would be no such constraints.

Professor Scott: We say in our vision document that we will work with providers to look at the economics of using robots. We are currently gathering together groups of the experts that we will require, and we are looking at how we can work with providers, perhaps through some sort of joint project.

The Convener: How far down the road are you? Have you just had a general discussion with providers?

Alpana Mair: We have had initial discussions internally with colleagues in capital planning and in procurement, because in procuring robotics we must go through official processes. The discussions have been about how we go through the process to engage relevant stakeholders.

The Convener: Are there a number of specialists in that field? Are we talking about two or three major companies world wide?

Alpana Mair: We have drawn on the expertise of our procurement colleagues, who tell us that there is a worldwide market and that they would undertake the normal processes to ensure that they go out to the relevant companies to tender, laying out specifications, so that companies can come forward with what they can offer. The advice that we have been given has been about following due process, to ensure that we get the best possible input into the pilots that we put forward.

The Convener: Have you looked at financial comparisons?

Alpana Mair: That is one of the pieces of work that we want the pilots to do. Some companies have shared with us issues such as return on investment and mapping work that they have done. Part of the pilot will be to do such work, so return on investment and the opportunity to release capacity for pharmacists to deliver in a face-to-face role are the kind of things that we put in the specification for the pilot work.

The Convener: You have got no further than notional figures, then. Do you have an expectation about the savings that could be made if we went down the robotics route? Both witnesses have job titles that reflect financial responsibilities.

Professor Scott: We work in the directorate that is headed up by the chief finance officer, who would not let us do anything without ensuring that we had gone into the economics and finance of it.

The Convener: Has none of that work been done at all?

Alpana Mair: It will take place as part of the pilot work, which will look at the capacity that can be released.

The Convener: Another issue is that in the world that we live in there are reserved powers and devolved powers. The Royal Pharmaceutical Society said in its submission that that would have to be considered in the context of the control of entry requirements and current legislation. What stage have you reached on such issues? Are they also in the wait-and-see category?

Professor Scott: Control of entry is a devolved matter for the NHS, and that is what the consultation is about. However, medicines legislation is reserved to the Medicines and Healthcare products Regulatory Agency. Alpana Mair might say where we are in that regard.

11:00

Alpana Mair: There is a UK piece of work that is looking at balancing regulation between law and professional regulation in order to cut some of the red tape around the matter. Although it is a reserved matter, each of the devolved Administrations is represented in the room so that we can share the issues that we face in delivering healthcare in our countries. I sit on that group, and one of the things that we feed in is the direction of travel that we want to go in with "Prescription for Excellence" and the opportunities to change things to enable pharmacists to perform a more clinical-facing role. That work is progressing.

One of the key pieces of work that is being progressed, to which we contribute by having a seat at the table so that we can discuss the issues that are pertinent to Scotland, is on supervision and how we can deal with that as we enable pharmacists to be away from the pharmacy to deliver patient care, if that is appropriate. We need a discussion on that, and it has already started as part of a UK-wide piece of work.

Dr Simpson: I have a very quick question on the minor ailments scheme. I had conversations with the First Minister of Wales when the Welsh Government introduced free prescriptions and I asked him whether it was going to introduce a minor ailments scheme. He said no, because the Welsh Government thought that it would be far too expensive with free prescriptions. For minor ailments, we have retained the current registration system that goes back to when we did not have free prescriptions. We have not modernised that system yet.

Professor Scott hinted in an earlier reply that the scheme is to help young families and people on lower incomes. Has the time not come for us, on a cross-party basis, which we are now beginning to talk about, to change the minor ailments scheme in some way to make it available only to people on low incomes and to families? Or should we take on the additional costs of making the scheme available to everyone but get rid of the bureaucracy that means that people still have to register for it? Someone who is diabetic can get free prescriptions and someone who is newly diabetic can access the minor ailments scheme free of charge, but they still have to go through a registration process that they would have had to go through previously when they did not get free prescriptions.

Sorry—my question was a bit long winded, but it is a technical matter.

Professor Scott: The registration process was designed to prevent even more bureaucracy in looking at bits of paper to see who was using the service at different pharmacies to collect lots of paracetamol or whatever. Registration is a good tool that tells us about the use of the service.

However, in "Prescription for Excellence" we talk about moving to common clinical conditions. At the beginning, you talked about every pharmacist becoming a prescriber. If we had common clinical conditions, pharmacists who were prescribers could take some of the workload away from general practitioners and pharmacy would be seen as the first port of call.

Dr Simpson: You see pharmacy taking over from the minor ailments scheme in the long term.

Professor Scott: We would move to that, but we will have to examine the costings and how that would work.

Dr Simpson: The minor ailments scheme costs about £18 million or £20 million a year at the moment, but it is limited in a rather odd way to certain people. Someone who suffers from schizophrenia cannot access the minor ailments scheme unless they also qualify on the grounds of age or finance. Someone who is able to work and has an income of more than £16,000 cannot access the scheme—is that correct?

Professor Scott: I do not think that it is about being able to work; it is about being on income support.

The Convener: Earlier, you mentioned a name change for the chronic medication service. Are you looking at the service in the round? What I am getting at is whether what you are considering is anything more than a name change.

Professor Scott: In "Prescription for Excellence", we talk about long-term conditions. That is where we would look, initially.

We hold regular discussions with the CPS and others, and we make changes to the chronic medication service by adding parts on to it, when that is appropriate.

The Convener: Is it just a name change that you are considering, or something more fundamental? Are you thinking about bringing services together?

Professor Scott: Initially, it will be a name change, but we will want to look at how clinical pharmacy prescribers engage with their GP colleagues. We have some extremely good examples—and the committee has been provided with good examples in the submissions—of pharmacists working with GPs to run clinics for patients with long-term conditions.

Some of the advice that we have been getting on the issue comes from senior medical officers in the department. One of them said that, if any member of the committee wanted to visit his deep-end practice in Glasgow to speak to the pharmacist there, that might give them an in-depth understanding of how the practice and the pharmacist are working together.

The Convener: To ask a straight question, is the chronic medication service to continue in its present form?

Professor Scott: It is, at present.

The Convener: Thanks.

I thank both witnesses for their attendance, for the evidence that they have provided and for the time that they have given up. We appreciate it.

11:07

Meeting suspended.

11:13

On resuming—

The Convener: Item 2 is the Scottish Government's pharmaceutical care action plan, on which we will now have a round-table session. It is a big table—there are many people here.

At this point, we normally introduce ourselves. I am the convener of the committee and the MSP for Greenock and Inverclyde.

Dr Andrew Buist (British Medical Association): Hello. I am a GP in Blairgowrie for three days a week. For two days a week, I am deputy chairman of the Scottish general practitioners committee of the British Medical Association.

Bob Doris: I am an MSP for Glasgow and deputy convener of the committee.

Martin Green (Community Pharmacy Scotland): I am a community pharmacist and the owner of a small chain of pharmacies in Glasgow. I am chairman of Community Pharmacy Scotland and a member of the Scottish board of the Royal Pharmaceutical Society.

Dennis Robertson: Good morning. I am the MSP for Aberdeenshire West. I am substituting for Richard Lyle at this morning's meeting.

Jackson Carlaw: I am an MSP for West Scotland, and the Conservative spokesman on health. I am substituting for Nanette Milne today.

11:15

David Pfleger (NHS Grampian): I am director of pharmacy for NHS Grampian.

Colin Keir: I am the MSP for Edinburgh Western, and a member of the committee.

Professor John Cromarty (Royal Pharmaceutical Society in Scotland): I am chair of the Scottish pharmacy board of the Royal Pharmaceutical Society in Scotland and former director of pharmacy at NHS Highland. I have a visiting professorship in the school of pharmacy at the University of Strathclyde.

Gil Paterson: I am the member for Clydebank and Milngavie.

Professor Norman Lannigan (NHS Greater Glasgow and Clyde): I am acting head of the pharmacy and prescribing unit in NHS Greater Glasgow and Clyde.

Aileen McLeod: I am an MSP for South Scotland.

Professor Stewart Irvine (NHS Education for Scotland): I am the medical director for NHS Education for Scotland.

Dr Simpson: I am an MSP for Mid Scotland and Fife.

Michael Pratt (NHS Scotland Directors of Pharmacy Group): I am director of pharmacy for NHS Dumfries and Galloway, representing the directors of pharmacy in Scotland.

Rhoda Grant: I am a Highlands and Islands MSP.

Dr Miles Mack (Royal College of General Practitioners): I am a GP in Dingwall in the north of Scotland. I am here representing the Royal College of General Practitioners as the deputy chair of policy.

The Convener: Thank you all. Gil Paterson will start us off.

Gil Paterson: I have a fairly straightforward question to get folk engaged. What benefits has

the previous strategy "The Right Medicine: A Strategy For Pharmaceutical Care In Scotland", which was implemented in 2002 by the Scottish Executive, brought to the delivery of pharmaceutical care services? How can the new strategy build on it?

The Convener: Who wants to take that question?

Gil Paterson: I can take it myself. [*Laughter*.]

The Convener: The question has come right round the table.

Dr Buist: I will make a start. As Professor Scott said earlier, the strategy represented a move away from a purely dispensing process to a public health, minor ailment and chronic medication service, with which GPs have engaged to a certain extent. We do not think that it is the finished article, and there are still a number of problems with it. I have about half a dozen to 10 patients on it, and two of them have asked to come off it for various reasons. We find it inflexible.

There are huge opportunities in moving to the new strategy, "Prescription for Excellence: A Vision and Action Plan for the Right Pharmaceutical Care through Integrated Partnerships and Innovation". We are positive that there is a great opportunity to improve the quality of patient care in the community in line with the 2020 vision to integrate our care and to share data. The strategy can, in my view, increase pharmacists' job satisfaction, and there are opportunities for the joint training of doctors and pharmacist students. It could—as was mentioned earlier—help with the GP workforce crisis that we are facing given that GPs are in short supply just now.

As I said earlier, I am a GP in Blairgowrie. We have been fortunate in NHS Tayside as we have had a practice pharmacist for 12 years. He is a member of our practice team and works with us for three days a week, and he has been enormously useful in improving the quality of the care that we provide to our patients. Some examples of that include undertaking medicine reconciliation when patients are discharged from hospital; liaising with the community pharmacists; leading on medication audits, polypharmacy reviews and nursing homes and on compliance with health board formularies; giving evidence-based advice on complex medications; and advising us on best-practice prescribing. In short, he has reduced our errors and increased our compliance and cost effectiveness, and reduced our waste and variation and increased our quality.

As was mentioned earlier, some of the proposals present challenges. Data sharing is one, although I do not think that it is insurmountable, and costs are another. Robots are mentioned in the strategy document; I do not know much about them, but I believe that they come with large price tags, certainly running into tens of thousands—and possibly hundreds of thousands—of pounds. They also need new purpose-built premises in which to operate, such as the premises in Larbert.

Richard Simpson mentioned that the pharmacy multiples are going to be a challenge. There is not enough thinking going into that.

Finally, I think that there are some threats within the ideas in the action plan. As Jackson Carlaw said, there is a risk of a muddle of unintended consequences.

I want pharmacists and GPs to work together in the community, but it is essential that they are working as part of an integrated team. If they are working in silos and are separated in that way, there is a risk of confusion of care and of no one knowing who is in charge of the patient's care. If we can get the IT to work, that can help to a certain extent, but the model that I am fortunate to have in Blairgowrie works because the pharmacist and I work closely in the same team and share patients. If we dissipate that model, there is a chance of a muddle developing.

The Convener: Thanks for that. You raise a lot of issues that have previously been discussed.

Dr Mack: I recall a lot of what Andrew Buist has said. The simplistic way in which I think about interprofessional working, which is key to this issue, concerns how pharmacy works with the rest of the NHS. It is about three things: being clearly focused on the patient's needs; being clearly focused on what our roles are and whether we understand the roles of others; and being aware of how we communicate. There is a great opportunity to consider whether the pharmacy skills that are out there are being used in the best way. I am not sure that pharmacists are always working to the top of their licence.

The process of communication between the pharmacy and the GP is crucial. We talk about the primary care team. In this situation, however, it is far better to see it as a network. GPs have traditionally been a major hub in that network, as people come to us as a first port of call. Sometimes, people do not use pharmacists to do that, and the proposal contains huge opportunities to integrate pharmacists better in the NHS in a way that will enable them to signpost people in the right way.

Part of that signposting will be to general practice. I am aware of that. The common conditions cover a certain number of areas. The reason why people come for professional advice is that they want to get some advice about whether their complaint is serious. One thing that I think is crucial concerns how we provide decision support

to each other. Andrew Buist has given examples of how pharmacies can provide decision support to GPs. I think that that provision of specialist help should happen both ways and that there should be a dynamic not just between the GP service and the pharmacy service but between the pharmacy service and the rest of the NHS primary care network.

Professor Irvine: I think that an important contribution to professional working can be made by interprofessional education and training. NES has been advocating for that strongly at the undergraduate level, with medical and pharmacy undergraduates training together, and through some of the continuing professional development packages that we deliver, which involve GPs and pharmacists being trained together.

Professor Lannigan: The first question concerned what "The Right Medicine" had made a difference to. When NHS Greater Glasgow and Clyde considered what we had achieved over the past few years, I was surprised to see how much of it was in line with "Prescription for Excellence". I think that "Prescription for Excellence" is a continuum. I will give you some examples.

A hospital patient now gets their medicines from their bedside locker. We can support them to take their own medication, if they are fit to do so. Our hospital pharmacist then shares information, with the patient's permission, with the community pharmacist. We know that, in the case of one in four discharges, the community pharmacist makes use of that information. For example, they might reinforce a message about the new or changed medication that has been explained to the patient when they were in the hospital bed, at which time the patient might have been thinking only about getting home.

There are a number of clinics for high-risk medicines, such as warfarin. Depending on the setting, they are run by community pharmacists, working in partnership with GPs or specialist pharmacists. A clinic in Inverclyde is considering a reduction of inappropriate prescription of antipsychotics, again working as part of a team.

Increasingly, pharmacists are seeing housebound patients in their own homes in order to review their medication—that never happened before "The Right Medicine".

We recently started an initiative with East Renfrewshire Council as part of health and social care integration. A lot of activity has been going on and I see "Prescription for Excellence" as a vision that supports that continuum. We want to try to increase that integration. We heard earlier about the possibility of virtual teams, but we can also have real teams. We have had real teams in hospitals for many years, with people working together and understanding and respecting each other's roles.

Michael Pratt: Professor Lannigan used the term "continuum" and that is my view, too. "The Right Medicine" and the new contract in pharmacy allowed the traditional pharmacists to free themselves to some extent from the dispensing bench, much improving the direct delivery of clinical care to patients and increasing the capacity within primary care. That has been to patient benefit.

The term "continuum" is absolutely right, as the "Prescription for Excellence" takes us further along that road. The end point of the "Prescription for Excellence" is quite visionary, but the next steps are along our current direction of travel and it is important to recognise that.

We have already heard about some issues around information systems—ensuring information flow is critical. Certainly when I speak to pharmacy and medical colleagues in my board, one issue that is in their minds is the need to ensure that the information flow exists so that at all points there is a clear understanding of the clinical care that is being provided to patients. We need to give careful consideration to that issue.

Martin Green: On a slightly different slant, Gil Paterson's original question was about relating the new action plan to the old one. "The Right Medicine" was quite prescriptive about what it wanted to deliver. As people read it, they could see where their role was within it and it was quite easy to define a set of objectives. When people have a set of objectives, it is quite easy to plan how to meet them. We had things planned out and structured, we knew which elements of the plan we were going to introduce first, and so on and so forth.

"The Right Medicine" introduced patient registration through the minor ailments service, which hugely increased access to medication, and it introduced public health services. Through those services, it began to set out pharmacy as perhaps the first port of call when a patient enters or accesses the NHS.

Our chronic medication service was always going to be the biggest and most difficult element to implement from the vision of "The Right Medicine". We are not there yet; we are still working on it. It is entirely dependent on moving to an almost paperless system. I say "almost" because in the first instance it will still involve paper. However, it is about moving towards an electronic system, which again registers patients to a particular pharmacy.

Where "Prescription for Excellence" differs from "The Right Medicine" is that in "Prescription for Excellence", it is not so easy to define what we are

trying to achieve and who will deliver it, whereas "The Right Medicine" was very much a vision for community pharmacy.

Professor Cromarty: I will try to address the original question from Gil Paterson about what "The Right Medicine" has achieved and I echo some of the comments that have already been made. We are now 12 years down the line from the publication of "The Right Medicine", so it is time for a revision of strategy and a new look at what we should be doing. For me, "The Right Medicine" achieved a great deal across many of its objectives and many of them have been successfully implemented. It has shown us models that work in helping to reduce the prevalence of iatrogenic disease, levels of which are still unacceptably high.

We live in difficult financial times. We have some improving health statistics, but we are not particularly effective at reducing iatrogenic disease, although the Scottish patient safety programme has done a great deal in that direction within secondary care and that work is beginning to roll out into primary care. You have already heard Norman Lannigan talk about the management of high-risk medicines, for example.

11:30

"The Right Medicine" did a lot for safe and effective care; perhaps it did rather less for person-centred care. "Prescription for Excellence" focuses on high-priority groups—vulnerable patients, who increasingly suffer multimorbidities and are subject to polypharmacy. Therapy is becoming much more complex and difficult to manage, so it is essential that the pharmacist, who is the expert in medicines, is a key stakeholder in any team that deals with a patient's therapy.

"Prescription for Excellence" is a natural progression from "The Right Medicine". It sensibly looks at the need to make medicines governance as good in the community as we have succeeded in making it in secondary care, in some instances. We have excellent area drug and therapeutic committee structures, with all the working groups that support them, but we need effective governance in primary care and the community, too. There are places that we do not seem to reach so well in relation to the therapeutic input. I am thinking of care homes, for example, and patients who cannot walk into the community pharmacy. The new strategy prioritises our focus on more vulnerable patient groups.

"The Right Medicine" tested some of the models that helped to improve patient care through the pharmacist's input; the new strategy gives us a framework. It is quite an open framework, as Martin Green acknowledged, and we will all have the opportunity to play in that network. When the concept of the general practice clinical pharmacist is advocated in "Prescription for Excellence", it does not matter, for me, which location the pharmacist comes from to plug the gap; what we need is someone who has the requisite clinical skills, who is part of the healthcare team and strongly engaged with the GP in the management of the patient, and who can bring pharmaceutical care skills.

Whether that person is a hospital pharmacist, a community pharmacist or a primary care pharmacist is less important. We need all three groups to be involved, or we will not deliver the approach and the Government will not deliver its 2020 vision, given that "Prescription for Excellence" underpins 10 of the 12 priority areas in the 2020 vision route map. Unless we get medicines management right, reduce waste and prevent some preventable iatrogenic disease, the 2020 vision will not be delivered.

The new strategy is therefore really important. Okay, perhaps we were not able to answer some of the questions that the committee rightly asked this morning, but we are setting up a number of working groups that will test such issues and we will be in a position to report in that regard as the strategy unrolls.

I think that the profession is hugely excited by the opportunity. The strategy is exciting, and not just in Scotland; it is the envy of national Governments in the UK and beyond. We have a tremendous opportunity to make it work, provided that we get effective models of care and provided that collaboration with health and social care teams works.

The Convener: If no panel members want to respond to what Professor Cromarty said, or to anything else that they have heard, I will bring in a committee member.

Rhoda Grant: I am interested in how we deliver pharmaceutical services to communities in remote and rural areas. An offer of pharmaceutical services usually means withdrawal of GP services, which has been hugely controversial in many areas. How can we provide the public with both services, so that they can access pharmaceutical services without there being damage to the GP services that they need? If there is a hierarchy of need, people say that they want GP services first, but then they miss out on pharmaceutical services. How do we do both?

Michael Pratt: Let me start by saying that I do not have an answer. I come from Dumfries and Galloway; we have a large number of dispensing practices in our community. Three years ago I put a challenge in our pharmaceutical care services plan, and wrote that we needed pharmacy and

general practice to work in partnership to deliver a full service to rural localities, without losing the medical aspect that is required. I have to say that we failed on that objective in the plan, because we could not come up with a realistic solution.

However, there will be opportunities as e-health and telehealth systems develop, and as information flow improves. We need to explore those opportunities so that we can have effective remotely delivered services in those localities. We need to test those models under "Prescription for Excellence". Rhoda Grant is absolutely right that we do not want to put at risk or lose medical services in remote and rural communities, because they are absolutely essential. However, we also need to provide a full range of services to those communities.

Professor Cromarty: I will respond directly to Rhoda Grant's question. I am from the Highlands, and last week we held an NES evening with 10 videoconferencing sites in NHS Shetland, NHS Orkney and NHS Western Isles, and nine sites in NHS Highland. I was gratified to hear about some of the proposals for early work on "Prescription for Excellence" that came from that patch, which is a large part of remote and rural Scotland. A number of community pharmacies and managed services have been approached by dispensing GPs asking how the pharmacists could work more closely with them in providing pharmaceutical care to patients.

We can park the dispensing issue, on which there are a lot of red herrings and misinformation and which is not the focus of the debate. The debate is about how to get pharmaceutical care to patients who do not see a pharmacist; it is not about where they get their prescription from. I am heartened by the fact that some of the initiative is coming from dispensing GPs who recognise that they can improve their patients' care by gaining the services of a pharmacist in the practice.

We are looking at outline proposals for telehealth-type consultations in which the pharmacist is in a remote centre but can videoconference into a patient consultation to give their pharmaceutical input, at the point of prescribing or at the point of polypharmacy or medicine review.

We can find systems that will work and through which dispensing GPs and pharmacists from any of the sectors can work jointly. One project that is progressing involves a dispensing GP practice and community pharmacy in Skye, but we have heard about similar approaches in Orkney, Shetland and elsewhere in the Highlands. People are considering ways in which to manage the issue. Whatever the outcome of the debate about who dispenses when there is an application for a community pharmacy in a place where there is an existing dispensing GP practice, we will have a large portion of Scotland in which there will be no applications for a community pharmacy, so we still have to solve the problem of how to get pharmaceutical care to patients in remote locations. We have to examine and test novel ways to make that work for patients. Some patients might come to Inverness and go to a community pharmacy while they are there, but we need to consider how we get the routine care effectively managed with the input of a pharmacist, and that is a challenge.

There is a numbers game. To go back to the convener's questions to the previous panel about workforce, we need to consider how we manage capacity within the managed service or community pharmacy to provide pharmaceutical care in the places that do not currently receive it. That is not an easy challenge, but testing of some of the models that could help to tackle it is under way.

Professor Irvine: One area in NES for which I am responsible is what we brand the remote and rural healthcare educational alliance, which is aimed at supporting the education and training that are needed by all professional groups in remote and rural healthcare. There is no doubt that there are huge challenges in delivering that agenda. One of the most compelling messages that comes through consistently is about the need to grow your own, as it were. In other words, if we get healthcare professionals who come from remote and rural backgrounds into education and training, they are much more likely to go back and work in those remote and rural backgrounds. We are doing a lot of work across all the professional disciplines on how to support and sustain that.

It is also important to draw attention to the use of technology to deliver education and training in remote and rural areas to support the often very isolated practitioners across all the professional disciplines.

Dr Mack: I am glad that Rhoda Grant asked about remote and rural areas, because that is a big issue and one that we are interested in at the moment. We are really worried about how to maintain good services in those areas. We need to remember that the NHS was invented in one of those areas; it was proposed by Lachlan Grant in Ballachulish, in 1912, and the Highlands and Islands Medical Service was piloted in our patch.

We should grab the chance to use these real crises to pilot new ways of working. However, we are well aware that the loss of dispensing has sparked quite a few crises in small rural practices, and we are worried that that will continue. We were grateful for the recent consultation on the matter, and for the fact that it is being taken seriously. I hope that some of the areas that are experiencing problems will be helped by that process.

It will always be difficult in areas with small patient populations and few clinicians. Even if the proportion of clinicians is quite high, it may be just a nurse and a GP. We must not lose the expertise that dispensing GPs, in particular, have. They provide fantastic community-based services to their patients and, in a lot of ways, are the envy of those of us who work in less remote areas. If the proposal in "Prescription for Excellence" is going to work, it will have to work in those areas, too.

David Pfleger: There will always be areas where we need dispensing practices. We must first recognise that those areas are not getting a full pharmaceutical care service as it stands, and then work out how we can build on the existing services to deliver a fuller pharmaceutical care service, where that is possible. That is partly about how we support our dispensing doctor colleagues, particularly in relation to the dispensing element of their role. I have spoken to colleagues, and that bit sometimes gets left out when support is provided by health boards. We are looking at that locally.

We must also look at how we plan the services. Thinking back to the pharmaceutical care service plan, we should consider how we involve dispensing doctors in delivery of pharmaceutical care services, and we should recognise that they, as well as the pharmacies, are part of that network. That will be important moving forward. I hope that the consultation that we have just gone through will give us some tools to provide a bit of stability and a clearer direction of how the pharmaceutical care service planning process will help to support that.

The Convener: A housing scheme can be remote and rural, too. In my constituency, the community pharmacy may be the last outpost if the local shop has shut down. We all know the scene. If the future is that we will have more centralised dispensing, how viable will those outposts remain? We have discussed with GPs at the deep end the issue of providing equal access, time and support for such communities. A wee issue that has come out of this morning's discussion that gives me some concern is how, in a model of centralised dispensing, we can sustain pharmacies in poorer communities. Should not that be considered among all this other stuff?

Professor Lannigan: I totally agree. The prescription for excellence policy will build on the unique selling point of community pharmacies, which is that they are accessible and available in exactly the situation that the convener has described. The community pharmacist is often the most accessible clinical practitioner in such areas, and that is really important. Glasgow is usually regarded as an urban area, but we have rural areas, too.

The majority of smoking cessation attempts in NHS Greater Glasgow and Clyde are made through community pharmacies—very successfully. Last year, 30,000 patients attempted to quit and there was a 30 per cent success rate after four weeks. It is pretty important to us in Glasgow that we maintain that and that it is done in the heart of those communities. If you leave dispensing to the side, that will become less and less important to those pharmacies in terms of retaining their income, because their income will be derived from pharmaceutical care, if we get this right, and dispensing will become more of an overhead.

11:45

That might drive community pharmacies to find novel ways of providing dispensing services efficiently and cheaply. There is some evidence of that. Some community pharmacies are already investing in robotics, in pharmacy technicians and in coming together in hubs to dispense. Community pharmacies are being quite creative in managing the supply side, and if they derive their income from providing care—which is where I hope they will go—I have no worries about the viability of pharmacies in areas such as housing estates. In fact, it might actually mean that there is more demand to put care in those places.

There is also an element of provision of care in patients' homes, for patients who cannot get out. Many community pharmacies now provide home delivery for prescriptions. That is a starting point, but many will also visit patients in their own homes to provide that pharmaceutical care. For the type of populations that we are likely to see by 2020, that will become the standard for the pharmaceutical service.

Martin Green: I too have a concern for pharmacies—not just in rural areas but in urban areas, because there may be outposts in urban areas, and not necessarily on main streets, where we are providing dispensing services from some form of factory. The range of services that we provide are all cross-subsidised. There is hardly a single service that is provided by a community pharmacy that can stand on its own two feet financially, with the exception of the dispensing service. There is a financial aspect to dispensing in a different way, because the dispensing service significantly subsidises all the other NHS services that we provide.

Parking that to one side, though, the opportunistic access that we have to patients as they present to pick up their medicines is unique. We have the ability to access patients who would not willingly go to other elements in the NHS, so although we are more clinically focused and are expanding the range of services that we deliver,

we must be careful that we do not throw the baby out with the bath water; we must remember the unique benefit that providing a dispensing service brings with it.

Dr Simpson: I have a supplementary question. It has been a useful discussion; the point that Martin Green has raised is critical. If we are funding the service through one element that will be made less costly by robotics, hubs and centralisation—the dispensing—but we continue to fund other elements, we will have a problem with cross-subsidising. It seems clear to me that urban areas and very remote and rural areas require different models and that we need a new model to continue dispensing from a GP-based hub or centre in remote and rural areas.

The interface between those two is the real problem, and we have that here and now. In my area, GP services in Leuchars and Methven have been significantly curtailed in branch surgeries as a result of their losing dispensing. That is a reality. My constituents in Methven now have a general medical service from 1 o'clock, whereas previously they had it for the whole day. It has been cut in half as a result of losing dispensing, and Leuchars is the same. We need to decide how to deal with that interface. The increased viability of community pharmacy is leading community pharmacists to establish themselves and to provide a better and more rounded pharmacy service, which is welcome, but if it damages GMS that is a real problem.

Does anyone have any comments on how we tackle this changing interface, which will change even further—that is the point that Martin Green made—as the mechanism for formal dispensing changes? We will have a real problem with that area.

Bob Doris: I was struck by Professor Lannigan's comment that dispensing can in part be a red herring. That clearly relates to the business model. If you are a dispensing pharmacist on a busy high street, you can make substantial amounts of money. Yes—you do all the other things, but that is the business model around the outlet.

Mr Green mentioned the idea of pharmacists becoming outposts. In Sighthill in Glasgow we have lost the dispensing pharmacist. Everyone still gets their blister packs, but that is not the point. In an area that needs to be regenerated, we need the bricks and mortar of a community pharmacist. The business model might not be there, but they are the only allied health professional in town for all the other forms of care that you would want the community to engage with on the ground, via the bricks and mortar.

My question is similar to Dr Simpson's. Do we have to reconfigure the business model around community pharmacies to incentivise things other than dispensing, so that we can put community pharmacists in areas that are nowhere near health centre hubs, rather than just round the corner from a hub, where they are in competition for dispensing profits? I mean that with love; I am trying to ensure that we get the community pharmacists where they are really needed.

David Pfleger: There are lots of points to respond to there.

The issue of cross-subsidisation across pharmacy services, but also within dispensing doctors, needs to be at least brought out into the open, and then considered.

I agree with Norman Lannigan that we are seeing supply efficiency driving robotics now. Regardless of where we go with contract payments in the future, we are seeing it now, and it will continue. In my view, it will not be the Government that drives the robotics revolution; it will simply be about supply efficiency. The same will be true of dispensing doctors. I am sure that at some point they will access pharmaceuticals in that way, to be delivered back to what you have called the dispensing doctor hub.

I return to the issue of the urban area where we see an outpost pharmacy. One of the key reasons why we like GP practices as a source point to put services through—apart from all the wonderful personnel there—is that we can look at the people on the list and work out what their needs are, because they are a registered group of patients. As registration for community pharmacy increases, we will increasingly be able to do the same with a community pharmacy. That will create a value in those outposts that is not necessarily seen there now. We will be able to say what the community's health and their needs look like. We will know that the community is using the pharmacy because they are registered for services there; therefore, we will not just use those bricks and mortar for pharmacy, but will seek to put other services there as well. Such a pharmacy would become an extension, if you like, of the primary care network—network is a better word than team, which I think is limited.

Smoking cessation is a great example of where community pharmacy is pretty much delivering the health improvement, efficiency and governance, access and treatment—HEAT—target across the country. If we use that as an example and think along the lines of how we upskill, train and acknowledge some of the other staff whom we are using in community pharmacy to deliver health improvement messages, we will create a value around the outpost pharmacy. I do not necessarily like the term "outpost pharmacy", but it is a useful

one to use today. That is how we will create the value. Once there is value, people want to invest.

A long time ago, in 2003, when we had the original consultation on control of entry, we talked not only about identifying areas of unmet need for pharmaceutical services but about overprovision, which has gone off the agenda completely. That answers the question about where the market will not support a pharmacy at the moment, where we think we need one and how we use a system of either incentivisation or subsidisation to get that service into a particular area.

Overprovision is not on the agenda, as I said—it does not come up in "Prescription for Excellence", and the issue was pretty much dead after the 2003 consultation, but it may well be worth revisiting it. As the business model changes, if we have consequences that are not what we were aiming for, we need to think about how we move from overprovision to underprovision.

Dr Buist: "Prescription for Excellence" contains a lot of good ideas, but it does not paint a picture of where we are going. It talks about "new and innovative models" but, tantalisingly, it does not say what they are.

When we discussed health inequalities earlier this month, we spoke about outpost pharmacies in deprived areas. We need to build around the health hub in the community. The natural hub is the general practice. I want closer alignment of the community pharmacy, the general practice and all the other services, including the district nurse and the community psychiatric nurse. It is only by sharing the registration of the patients that we will avoid getting into a muddle, which is a risk.

In my town, we have two practices and two pharmacies. In Glasgow, there might be 50 practices and 50 pharmacies. How can we possibly share the care of prescribing for hypertension, for instance, if pharmacists prescribe but people do not know their pharmacist?

We need to think about separating off the dispensing element, so that we can utilise pharmacists' skills and bring them into the primary care hubs in deprived areas.

Martin Green: I return to the issue of cross-subsidising services, which is a common theme in dispensing general practices and in community pharmacy. However, dispensing general practices and community pharmacies are not directly comparable. There is more than just cross-subsidy in community pharmacy. In fact, it would not be financially viable to do anything else without the dispensing service, which fundamentally supports every other service. In effect, it delivers those other services within the NHS very efficiently.

For instance, I deliver the minor ailments service through my pharmacies every day of the week. If I was to pay for that service out of the money that is received for it, that would cover only the staff costs for four days. Providing a broad basket of services through a community pharmacy is a very efficient approach.

Professor Cromarty: I acknowledge that there are very significant logistical constraints in the present system, which does not work. It is a great pity that Dr Hamish Wilson and Professor Nick Barber were unable to be here today. I hope that all members of the committee have read the Wilson and Barber review. At the outset is the evidence base for why we are here. We are here because Scotland wastes £30 million a year on the unnecessary use of medicines. We are here because up to 15 per cent of patients are admitted to hospital as a result of iatrogenic disease. As if that is not enough, we give a further 10 per cent of hospital in-patients drugs to which they have an adverse reaction. The cost of that to them is ill health, and there is a financial cost to society. For the more vulnerable patient groups, including elderly people with complex conditions and those in care homes, the incidence of preventable adverse drug reactions can go up as high as 30 per cent. We also have huge levels of non-adherence.

Let us not talk about protecting a system that delivers effective pharmaceutical care, because the present system does not do that. Professor Barber and Dr Wilson spent a year looking at the evidence base across general practices and community pharmacies. They looked at where pharmaceutical care is provided and considered what happens to patients who do not receive it.

The models on which "Prescription for Excellence" was built have been tested. That was not dreamt up, but it was not explicit, because a mix of models have been shown to work through the efforts of implementing "The Right Medicine", through collaboration by the deep-end practices and through other effective collaborations between GPs and community pharmacists. We have evidence of what works.

We need to release the pharmacists' professional time and enable them clinically, through the efforts of NES and health boards, so that they all come up to the level of clinical skills at which they can provide effective pharmaceutical care.

However, it is no use defending a very time-consuming dispensing process as if that is what matters. What matters is releasing pharmacists' time so that they provide more effective care and we reduce the prevalence of unnecessary iatrogenic disease. The situation is not acceptable. Projections from across the water in the United

States have demonstrated that the cost of iatrogenic disease—much of which is preventable—exceeds the cost of conventional healthcare.

12:00

That is why "Prescription for Excellence" exists. It is about us collectively—the whole health and social care team—doing things more effectively to avoid harming patients through the use of medicines. There is a great deal of scope for us to do that, which, at a time when the Government does not have new money, will save money that we can invest in extending good models of care to those who do not currently receive it.

Let us please remember why we are here and why "Prescription for Excellence" exists. We all need to work very hard at overcoming the logistical barriers. Some of those barriers will concern particular stakeholders, of course, but they come within the scope of the Government's work on modernising the GMS contract and the community pharmacy contract.

The Convener: I want to let other people in, professor.

The system is broken. Does Martin Green want to comment on that?

Martin Green: That is what I, too, heard. I accept that the statistics clearly demonstrate that things need to be done better, but I contend that the system is not completely broken and that we do not need to reinvent it. I also contend that, if we agree with the direction of travel in "The Right Medicine", the chronic medication service is the backbone—certainly in the community environment—through which we would ideally provide more clinical care. However, the service is not yet fully implemented, so we are not really analysing a fully delivered model.

On patients with a particularly high level of need, such as those in care homes, I point out that since the advent of the chronic medication service, which is the way in which we would ideally deliver clinical care, patients in care homes have been excluded from it.

We have looked at the current system and have been critical of it in many ways, but we have held it back.

David Pfleger: I will pick up on two issues.

First, let us not delude ourselves that the dispensing payments that go to community pharmacy are for sourcing, labelling and handing over medicines—they are for more than that, and I think that Martin Green would be the first to say that. There is advice, the concordance discussion, compliance and so on—all the support for the patient that goes with that. When we talk about efficiencies in the supply bit, we need to be clear that this is about sourcing to produce an accuracy check.

Secondly, I come back to Andrew Buist's point about pharmacists prescribing. "Prescription for Excellence" is a 10-year plan; it is not something that will get turned on overnight. There is an issue about how we grow our existing systems, and this is about delivering that network.

I agree with the concerns that could arise around ensuring that care is absolutely co-ordinated and delivered within an agreed pathway to agreed guidelines and that information is shared, because we do not want two arms of care being delivered that do not speak to each other and are not co-ordinated. I see GPs continuing to co-ordinate care, but I also see a role for independent in-pharmacy prescribing, particularly around acute things.

We are currently treating uncomplicated urinary tract infections in Grampian in-pharmacy. That absolutely opens itself up to an independent community pharmacist prescribing role.

Lots of good things are being said, but we need to remember that this is a 10-year plan. I do not think that it is a case of all or nothing, because we will develop over time. On the point about the plan not being as prescriptive as "The Right Medicine", I see some advantages in that approach, because it enables us to think about how, on a local basis, we fit it into the changing models of delivering primary care and integrating healthcare delivery with social care.

Professor Irvine: Professor Cromarty rightly drew attention to the importance of education and training in underpinning a lot of what is required. It is important for the committee to be aware that most of the building blocks that we need for what is in "Prescription for Excellence" are in place already through undergraduate training, pre-registration training and the vocational training scheme that NES runs. If I were to be self-critical, I would probably say that the scheme is focused very much on secondary care and that we need to do a piece of work that looks at how we can make it more focused on primary care.

The commissioned work around independent prescribers' training is also important. I think that we now have about 800 trained independent pharmacy prescribers, who deliver significant numbers of prescriptions. I suggest that there is significant scope for delivery through that trained workforce.

The Convener: I suppose that, from the committee's point of view, it is not just about the training of pharmacists, GPs or, indeed, the new health workforce. When it comes to the 2020

vision, delivering all those services in the community will require a new type of workforce altogether. On the raw numbers, how many GPs and pharmacists will be needed? What areas will they specialise in? Do we need more technicians or more expert carers? Is some broader thinking taking place beyond the individual specialisms?

Professor Irvine: Your comment draws attention to one of the comments in the document around workforce planning and some of the weaknesses in that area for this professional group. In pharmacy, it is relatively easy to do workforce planning around the managed service, but it is a little harder to do it around the community service. Our organisation certainly has significant intelligence around dentistry and nursing that gives us some confidence that we could contribute more to workforce planning in pharmacy.

Your second point relates to the need to completely change the model, which is very much illustrated by work that is going on across the whole UK. About two years ago, a process was embarked on to look at the shape of postgraduate medical education and training, with the precise aim of addressing the need for more care in the community, greater generalism and less specialism. I think that I can very much reassure you that work is going on to address those priorities.

The Convener: The committee might take an interest in that wider aspect.

Andrew Buist and Martin Green want to come in—we cannot stop them now, which is good.

Dr Buist: I will just come in with some numbers. A workforce survey that we did last year showed that there were 3,730 whole-time equivalent GPs across Scotland, which was a small rise on the previous three years.

In my 10-hour working day, I reckon that probably between half an hour and an hour of my time is taken up with signing repeat prescriptions, sorting out specials and so on, and possibly much of that could be done better by an attached pharmacist. Up to an hour of my day is taken up with long-term conditions management: adjusting doses of blood pressure treatment and so on. Therefore, between 10 and 20 per cent of my time in a working day could be freed up. To do the maths, that would mean that, across Scotland, between 300 and 400 whole-time equivalent GPs could be freed up to get involved in work that is more particular to their skill set, such as looking after the frail elderly and keeping them out of accident and emergency.

Martin Green: I want to pick up on the theme of workforce planning and the development of skills in the broader pharmacy team. We need to make an early decision on whether we are going to make widespread use of the likes of automation, because the savings generated by automation are a result of paying off support staff. Should we invest in our support staff or should we look to automation?

I recently visited Holland—the Dutch model keeps getting mentioned, so I needed to find out what was going on. About one in five Dutch pharmacies use automation. As Andrew Buist mentioned, automation completely transforms the pharmacy, because it is necessary to design the pharmacy around a robot. The efficiencies are generated as a result of paying off support staff. The efficiencies that the companies who sell the machines will show you are all to do with paying off support staff and full-time equivalents. I am not sure whether that is what we want to do, but we need to make a decision, because we are currently training our support staff to take on more roles.

This is not directly related, but I have a comment to make on the concept of a general practice clinical pharmacist. I need to find out soon what that is. What does the term mean? I imagine that such people are prescribers, as provided for in “Prescription for Excellence”. If they are, we have some serious workforce planning issues to address if we are to turn all these people into prescribers.

I would like to throw out the idea that it is not necessary to be a prescriber to deliver the kind of care that community pharmacies can deliver, because most prescribing is done on an acute basis, and acutely unwell people are likely to go and see their GP. If someone who is managing a patient with long-term conditions wants to make an adjustment to the person’s medication, it is more than just courteous to pick up the phone and speak to the GP. The need for pharmacists to be able to generate prescriptions is not huge. I hear that from a number of prescribers. I am not one, but I have been told by people who run prescribing clinics that the occasions on which they are called on to write prescriptions are quite limited.

David Pfleger: I return to Andrew Buist’s point about how much time we can take out of the existing GP process in relation to the management of long-term stable patients. I think that the issue with the CMS is that many practices are still on the uphill bit—they have not reached the point at which they can see a significant reduction in the repeat prescription pile. In my local area, there are GP practices that have reached that position. For them, it is a game changer; those GPs can see the difference that that makes in terms of serial dispensing.

We can add to that the potential that prescribing by pharmacists offers in the medium term. Let us

not get into the nuances of "independent" and "supplementary", but, essentially, the fact that a management plan for a long-term patient has been agreed with the GP means that adjustments can be made within that without the pharmacist having to do the technical bit of getting the GP to sign them off, because it has already been agreed that, in response to a particular change in the patient, a certain course of action will be taken. That is extremely valuable.

If they were asked whether they need the ability to prescribe now in their current practice, many pharmacists out there in the community might well say no, whereas in hospital, the answer would be completely different. Hospital pharmacists use that ability every hour of every day. If we can explain to community pharmacists what the future looks like, I think that they will certainly see where independent prescribing comes in. I acknowledge the issue of co-ordination that was touched on earlier.

Let us not underplay the potential value of prescribing by pharmacists not only in unlocking GP capacity, but in unlocking pharmacists' capacity to deliver what they were trained to deliver. They are not trained just to supply; they are trained to deliver pharmaceutical care and, under the current format, we are not making the best use of that.

Professor Cromarty: I think that it would be extremely useful to get a prescribing community pharmacist, a prescribing hospital pharmacist and a prescribing primary care pharmacist to give evidence. Such evidence was given to Wilson and Barber—it forms part of their report. That is what "Prescription for Excellence" is built on. There are distinct advantages to prescribing.

12:15

I contest Martin Green's comment that most prescribing is acute. We all know that 70 to 80 per cent of prescriptions are repeat prescriptions for long-term conditions.

It is important that at the time of prescribing the prescriber has to hand the patient's pharmaceutical care plan. Currently, a prescriber might have that plan in their head when they see a patient, but I know from speaking to my GP that when he writes one of my repeat prescriptions he does not see all the therapy that I am on. He is not aware of all the other medication that patients are on when he spends an hour writing a large number of repeat prescriptions. In my book, and in his, that is not effective therapeutic management. Patients are not being reviewed at the time of the repeats because of the sheer workload that is involved—the hour a day that I think Andrew Buist said he can spend writing repeat prescriptions.

Who is reviewing the medication at that point? Where is the patient input, to tell the prescriber whether the therapy is still going well? If we champion someone to take care of the patient's pharmaceutical care, they can have the plan in front of them when they write the prescription and they can review how the patient is getting on with the therapy—whether it is the right dose, whether there are side effects and so on. We have the opportunity to do more effective monitoring, irrespective of whether the prescriber is a GP or a pharmacist—although I would argue that a pharmacist is in a better position to take account of over-the-counter medicines, other effects and health promotion opportunities, and would have the time to do that in a dedicated clinic. That could change the nature of prescribing. That is why it is important, and not incidental, that the pharmacist prescribes.

Michael Pratt: I am slightly concerned that we are discussing the needs and capacity issues of today. We must bear in mind that "Prescription for Excellence" sets out a 10-year plan. Given that prescribing volume grows by 3 per cent year on year, and given what we know about the demographic changes that are coming, if they are not already here, the capacity needs of primary care services in 10 years' time will be vast.

We need to do something different if we are to meet the capacity needs of the future. We need to use every set of skills that is available in the community. We have a valuable and highly trained resource and we need to consider how we use it. If that requires community pharmacists to get involved in prescribing and use robotics more in dispensing, we have to look at such solutions. Our focus needs to be on tomorrow, not today.

Gil Paterson: If the Government and everyone else agree that we want pharmacies to do different work, is the answer a reconfiguration of how we dispense—if I may use that word—the rewards for working in the area? I am speaking as a businessman, because that is really what I am. If the finances are not right and services cannot be maintained, surely we need to pay pharmacists differently. We could taper in change over time—we are talking about a 10-year programme—so that people did not have to rely on a particular aspect of the service. It worries me, as a businessman, that knocking dispensing out of pharmacy might knock out everything else. We need some logical way to reconfigure how people are paid.

Martin Green: You would need to do some firm financial modelling on that. Whether we like it or not, most community pharmacies are supported by their dispensing income or an income that is related to their former dispensing income, and if you wanted to encourage different behaviour by

rewarding them for doing other things you would need to bear in mind the efficiencies that are gained by doing everything together. If you begin to break up the services that pharmacies provide, you will need to meet the costs of each individual service. There are great efficiencies to be made by pulling the service profile together and delivering services through community pharmacy.

I stress that the importance of the dispensing function is to do with not just the cross-subsidy but our unique access to patients.

The Convener: We have another 10 minutes. The committee's objective this morning has been to bring some of the discussion out, for our own information and for our report, and to explore the imperatives that are driving the changes. We have been involved in discussing the 2020 vision and the integration of health and social care, and we cannot expect to achieve much more than to bring out an existing discussion that has been raging for some considerable time among healthcare professionals. We are dealing with something that has been described as a vision, which is not set in stone but which needs to be discussed and delivered over 10 years. In the final 10 minutes of the meeting, perhaps you could tell us what you expect the committee to do, within our limited remit, to understand that policy area, and what priorities we should set ourselves for further consideration of the issues over the next two years of the parliamentary session.

Dr Mack: I would like to say something about the dangers of incentivisation, because it is relevant to medicines. In general practice, we have seen a large increase in polypharmacy, some of which has been driven by financial incentives that have come our way through the quality and outcomes framework, and it is particularly galling that, in the Highlands, we have been paid for an enhanced service to reduce polypharmacy. We need to be careful about what we incentivise and about what other parts of the health service are incentivising, because it could have an effect on prescribing in a wider context.

David Pfleger: I will not tell the committee what to do over the next couple of years, but I want to emphasise something that was said earlier. There has been a lot of discussion about community pharmacy, but my point is about pharmaceutical care in the community. From a pharmacy perspective, I would ask the committee to remember that, depending on the complexity of that care—because we will be putting more care out of hospitals and into communities, and patients will expect more complex care in the community—the pharmacy delivery elements of that care will involve the hospital pharmacists, the practice-attached or primary care pharmacists, as we have now, and the community pharmacists in the future. My plea is that you remember that we are talking about all that resource and not simply about community pharmacy.

Dennis Robertson: How do we ensure that the patient remains the central focus in taking the agenda forward? We are hearing about various business models—it is obvious that everything needs to stack up—but how do we ensure that the patient remains at the centre?

David Pfleger: The simplest answer to your question is that we should be organising our services around the pathway that delivers care to a patient. That is where the system-level co-ordination comes in, so that you are clear about who is doing what, at what point and in response to what changes or to what is placed in front of them by the patient. From the patient's point of view, they must be absolutely clear about who is assuring and co-ordinating their care. I see that as continuing to be, and probably expanding, the GP role. That is a personal view, because as care gets more complex the importance of that co-ordination role will increase. The patient and the co-ordinator of care also need to be assured about all the other people who are delivering care, so that they are sure not only that people are competent, but also that care is being delivered in the way that has been agreed, and in a multidisciplinary way, to meet the needs of the patient.

That will develop incrementally at first. The model whereby Andrew Buist works with the primary care pharmacist who is attached to his practice is a key start in this general practice/pharmacist model. I see that extending to community colleagues who are ready to move and to engage in an extension of that practice network. That will eventually move us to the point at which we have more community pharmacists developing that network model. I see there being integration and collaboration with the co-ordinator of care and other providers of care. Dennis Robertson is absolutely right to say that the patient has to know who is delivering care and who is responsible and accountable, and they have to know that the care is of high quality.

Dennis Robertson: How do you communicate that to the patient? How do you ensure that the patient is confident that they are getting the best possible care from the best possible person?

David Pfleger: Part of that is about clarity around registration for the service and who is delivering the care. I will be honest and say that part of it is about working with colleagues to deliver under the confidence that is already in the system. In the practice pharmacist model, where we have a GP already working with the practice pharmacist, confidence in expanding the network will come with the assurance that the service is

linked with primary care and with the practice as the patient understands it now.

Professor Cromarty: I will return to the point made by Michael Pratt about capacity and link it to the question that has just been asked.

Our collective effort in the provision of health and social care must be focused further upstream if we are to be more effective in stemming the tide of long-term conditions and debilitating complications. We just need to think of a couple of disease states in order to see huge problems of capacity. We need to look at the increasing number of diabetic patients and all the complications that that brings. We already have difficulty managing our renal patients, as well as our diabetic patients. The number of patients needing dialysis is ever increasing—there are big capacity problems.

Given that pharmacists are the third largest and the most accessible healthcare profession, it is incumbent on us all to enable them to make better use of their skills for the benefit of patient care. The sooner that care is provided on a continuous basis to a patient through registration, the more effective we will be at managing it.

The other point about the healthcare system is that patients and society are too dependent on healthcare professionals. We need to facilitate self-care and self-management, to enable patients to be partners in the management of their own care. They have to recognise that they have a long-term condition, which they can do quite a lot about to improve their quality of life, in partnership with an evolving network of healthcare professionals who facilitate that. Patients themselves need to play a big role in enabling that. Who is in charge of patient care? It should be the patient, not the GP and not the pharmacist. We need to put patients at the centre and enable that to happen.

Our focus on secondary and tertiary care is far too downstream. We need to get care out of hospitals and keep patients out of hospital, because, as a society, we cannot afford to keep increasing the management of patients in hospitals.

The Convener: I do not know whether that radical point about patients being in charge of their own care is a good place to stop. Are you anxious to come in, Martin?

Martin Green: Yes—if you do not mind.

I have heard today from my NHS colleagues that it is quite good that "Prescription for Excellence" is not very prescriptive, because it allows them flexibility in the way that they choose to deliver particular services. Such flexibility and uncertainty are not particularly useful for the commercial partners of the NHS who will be required to invest in their premises and staff, which they have done for the past umpteen years. We need to see something a bit more concrete in terms of what is happening and where we are going.

I accept that it is a 10-year plan and that it will be a bit of a journey, but we need some early quick wins in order to keep engaged and focused. There are probably some out there that are relatively easy to deliver and we need to latch on to them right away.

12:30

Professor Cromarty: The patient is in charge of their own care, and the businessman is in charge of his own business. PFE presents a golden opportunity to submit a business case to provide the care that is needed.

Where will the business cases come from? There is a huge opportunity for community pharmacists to participate in this, just as there is for primary care and hospital pharmacists. No one is preventing that: "Prescription for Excellence" solicits that participation. We would love to see business cases coming in to show how that care will be provided using the skills of community pharmacists.

The Convener: We are talking about going forward and being inclusive. I pointed out earlier that community pharmacists are not on the steering committee. Is that helpful, given that they see, perhaps incorrectly, too many of the downsides of the strategy or, at least, some of the dangers? Do community pharmacists have a claim to be on that steering committee?

Professor Cromarty: Hospital and primary care pharmacists or, indeed, academic pharmacists, who will also be involved in PFE, could have such a claim. It is important that the RPS sits at that table because we represent more than half of all pharmacists and two-thirds of all pharmacists work in the community. Community pharmacy is represented at the steering committee, as are hospital and primary care pharmacists.

The Convener: It did not look today as if you are all singing from the same song sheet.

Professor Cromarty: Progress depends on robust debate. The status quo is no longer acceptable, so we must debate the issues.

Martin Green: I know that that question was not directly aimed at me. As chairman of Community Pharmacy Scotland, however, I point out that we aim to provide the majority of care within our communities and we have made a direct request to be involved in the steering group, but we are not there. The convener said the word "hierarchy"

earlier and, whether it is intended or not, we are left with the perception that the hierarchy means that we are not at the steering group table.

The Convener: Professor Lannigan, you have the last word.

Professor Lannigan: I have to challenge that from the point of view of NHS Greater Glasgow and Clyde. We recently responded to the first initiative from "Prescription for Excellence" by including the chair and vice-chair of our local area pharmacy contractors committee in discussions about how best to take PFE forward. I think that if you asked pharmacy contractors in Glasgow, they would have a different view.

That builds on David Pfleger's point that "Prescription for Excellence" supports local initiatives. We have many initiatives that have been designed by health board pharmacists but delivered by community pharmacists. I could give you a list of different initiatives for which we have designed payment structures so that community pharmacists in Glasgow can deliver them. Local work within the "Prescription for Excellence" framework is the way ahead. I would hate the committee to leave here thinking that there is some kind of battle going on within the pharmacy profession. That is not my local experience.

The Convener: We will end there. I thank you all for your precious time, your evidence, and your participation in this morning's discussion. Thank you.

12:33

Meeting suspended.

12:38

On resuming—

Subordinate Legislation

Scotland Act 1998 (Modification of Schedule 5) Order 2014 [Draft]

The Convener: Agenda item 3 is consideration of an affirmative instrument. As usual with such instruments, we will have an evidence-taking session. Once our questions, if there are any, have been answered, we will have a formal debate on the motion.

I welcome to the meeting the Minister for Public Health, Michael Matheson, and the following Scottish Government officials: Morris Fraser, bill team leader for the Food (Scotland) Bill, and Lindsay Anderson, solicitor. I invite the minister to make a brief statement.

The Minister for Public Health (Michael Matheson): Thank you, convener, and good afternoon.

Since the Scotland Act 1998 was passed, the European Union definition of food has changed, and certain animal feeding stuffs are no longer considered medicinal. The Scottish ministers were given executive competence in line with that decision, allowing, amongst other things, secondary legislation to be made to give effect to EU law in this area. However, the Scottish Parliament's legislative competence was not updated, which means that, by comparison, an act of the Scottish Parliament is limited in so far as it can make provision in respect of food and animal feeding stuffs. This section 30 order will ensure that the Scottish Parliament's competence to legislate on food and animal feeding stuffs is better aligned with the Scottish ministers' executive competence to ensure that legislative competence rests on the EU definition of food and what now constitutes non-medicinal animal feeding stuffs.

I am happy to answer the committee's questions.

The Convener: Members appear to have no questions, minister. We will therefore move to the formal debate on the instrument on which we have just heard evidence. I remind members that, as this is the formal debate, questions cannot be put to the minister and officials may not speak.

Motion moved,

That the Health and Sport Committee recommends that the Scotland Act 1998 (Modification of Schedule 5) Order 2014 [draft] be approved.—[*Michael Matheson*.]

Motion agreed to.

The Convener: Thank you, minister, for that brief visit.

That concludes today's meeting. I thank everyone for their patience and participation.

Meeting closed at 12:42.

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