OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 28 January 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 January 2020

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HEALTH AND SPORT COMMITTEE
2nd Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Matt Barclay (Community Pharmacy Scotland)
Dr Ewan Bell (Healthcare Improvement Scotland)
Jonathan Burton (Royal Pharmaceutical Society)
David Coulson (NHS Tayside)
Dr Scott Jamieson (Royal College of General Practitioners)
Monica Lennon (Central Scotland) (Lab) (Committee Substitute)
Eileen McKenna (Royal College of Nursing Scotland)
Dr Lewis Morrison (British Medical Association)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 28 January 2020

[The Convener opened the meeting at 09:30]

Interests

The Convener (Lewis Macdonald): Good morning, and welcome to the second meeting in 2020 of the Health and Sport Committee. We have received apologies from David Stewart. I welcome Monica Lennon, who is attending as a substitute member. As this is Monica's first attendance at the committee as a member, I ask her whether she has any relevant interests to declare.

Monica Lennon (Central Scotland) (Lab): Good morning, convener. There are no relevant interests.

The Convener: Thank you.

I ask everyone in the room to switch off their mobile phones or to switch them to silent. Although it is acceptable to use mobile devices in the room for social media, please do not take photographs or record proceedings.

Medicines (Supply and Demand)

09:30

The Convener: The first item on our agenda is to take evidence as part of our inquiry into the supply of and demand for medicines. We will take evidence on prescribing from two panels this morning.

I welcome to the committee Dr Ewan Bell, national clinical lead for the area drug and therapeutics committee collaborative at Healthcare Improvement Scotland. We welcome back Matt Barclay, director of operations at Community Pharmacy Scotland. We also welcome Dr Scott Jamieson of the Royal College of General Practitioners and David Coulson, who is assistant director of pharmacy at NHS Tayside.

We have a range of questions, which I know you will all want to respond to, but do not feel obliged to answer every question. Questions and answers should be put through the chair.

I will start with a wider question about medicines and alternatives to medicines. We are considering medicines in the context of wider healthcare objectives and how far those objectives are met. What proportion of prescriptions do you think could be avoided with the use of suitable non-pharmaceutical interventions? What are the main barriers to that, and what scrutiny and appraisal are given for medicines versus non-pharmaceutical interventions?

I have asked a range of questions, but that should set the scene for us this morning.

Dr Scott Jamieson (Royal College of General Practitioners): You ask a really valid and important question. The specific question about the proportion of prescriptions is very difficult to answer, and only time will tell what a different approach might bring. Throughout Scotland, as primary care teams move towards the new general medical services contract, with wider multidisciplinary teams and more time freed up for GPs to concentrate on complex patients, time will tell. I hope that, as that happens and as we better utilise our services and resources, with our pharmacist and community colleagues building into those teams, we will be given the time and space to better explore all the non-drug options that are available.

I think that you are intimating and potentially suggesting that, with a 10-minute consultation, when a GP has a complex, multimorbid, polypharmacy patient in front of them, the easier path has historically been to prescribe medicines, but that is a very difficult thing to quantify retrospectively. If I had longer appointments or if

there was less pressure on our time as GPs, would we be better able to explore non-medicine options? It takes a bit more time, when patients come in, to discuss those issues. We have perhaps been living in a society in which patients have felt that something merits treatment—and rightly so—but is there always a treatment that is good for their condition? Sometimes there is, but sometimes there is not. Taking the time, having longer appointments and explaining things better to patients can allow for a better exploration of the options.

Throughout Scotland there is now really good evidence that all areas are looking at broadening their pathways to align themselves to more realistic medicine options. We are exploring and encouraging shared decision making and more patient-centred approaches, in which non-medicine approaches have to be included. That is my practice and I am sure that it is reflected in that of my colleagues. We want to value the time to explore those non-drug options.

I am hesitant to use specific examples, but chronic pain is a good example of an area in which there is pretty universal agreement that non-drug options should be more widely explored, because they are far safer to use and the evidence for them is as good as it is for medicine for chronic pain.

I am not sure that I would want to cite the BBC as a reference, but the "Horizon" programme on chronic pain that was presented by Michael Mosley a couple of weeks ago accurately portrayed the issues that GPs have in explaining and exploring non-drug options with patients—the time it takes to do that and to break down the barriers and explore why the patient has got to that point in the first place. That needs due process, because patients are experiencing difficult issues.

Matt Barclay (Community Pharmacy Scotland): Scott Jamieson outlined several areas, including the wider multidisciplinary team, of which community pharmacy is a part, where, in time, as the approach matures and we get used to more non-medical prescribing interventions as realistic medicine gains traction, it will be up to the other members of the team to support that primary decision making, whoever the prescriber is.

Scott Jamieson also touched on patient expectation, which is a big thing at the minute. There is a phrase, "a pill for every ill" and in general, patients come to a prescriber looking for a cure in tablet or liquid form. That probably has to change. Scott outlined the need to have more time for those conversations. Other practitioners in the multidisciplinary team can support that direction of travel by being aware of the options.

There is currently an issue for the wider team about who has access to referral pathways if they believe that it is appropriate to investigate a non-pharmacological intervention; there is a question about whether that needs to go back to the primary prescriber. Once the teams and the referral pathways in primary care mature, that will help.

David Coulson (NHS Tayside): I agree with the sentiments around what Scott Jamieson was saying. Chronic pain is a really positive example; we invest a lot of money in medicines, but what are the alternatives that we can invest our money in? Right now, the way in which the system is designed means that during a consultation it is quite easy for the prescriber to write the prescription and direct the patient along that medical pathway. We are not good at making it easy to access other pathways, which do not involve medicines.

In Tayside, we are doing an awful lot of work on the system to open up access to alternatives to medicines and to make it easy for all prescribers to direct patients down those pathways.

Dr Ewan Bell (Healthcare Improvement Scotland): I will not speak on behalf of HIS; I will speak as a consultant in Dumfries and Galloway, who sub-specialises in diabetes and weight management.

There is a lot of talk about social prescribing and the panel has referred to that, but there are other interventions that are non-medical but are not social prescribing, such as bariatric surgery, which is much more effective for the treatment of type 2 diabetes than any medicine. There has not been sufficient evaluation of different interventions outwith medicines in NHS Scotland.

The convener's final question was about scrutiny of non-medicines. The health boards have a variety of inputs—from the Scottish Medicines Consortium, the Scottish health technologies group, clinical guidelines, patient support groups and targets—and there is no national, once-for-Scotland comparison or health technology-type evaluation of those different inputs. There is no comparison of all those different interventions, and no ranking—I do not want to use the word "prioritisation"—of what NHS Scotland believes that it is important to deliver on.

Emma Harper (South Scotland) (SNP): Good morning, panel. I was interested to hear Dr Bell mention diabetes, because that condition often comes up in discussions about social prescribing. The NHS spends £1 billion per year on diabetes, £800 million of which is spent on dealing with avoidable complications. If we can move patients to weight loss, we should do so, and we should

probably put more effort into incentivisation and cost reduction. Do you have any thoughts on that?

Bariatric surgery is interesting. When I worked in Los Angeles, we used to do around 15 bariatric surgeries a week; the procedure was often used as a more rapid approach to kick-starting weight loss. Do we monitor how much bariatric surgery is carried out in Scotland per year, or the weight loss that is associated with the procedure?

Dr Bell: Again, I speak not on behalf of Healthcare Improvement Scotland but with my consultant hat on, from my experience of dealing with type 2 diabetes weight management in Dumfries and Galloway.

In 2013-14, there was an attempt through the national planning forum to standardise bariatric surgery in Scotland, in terms of who was suitable for it. That involved setting an intervention rate for each health board. However, there is a perception among some of my colleagues who work in weight management that the current restrictions are probably too tight. Almost 60 per cent of people with type 2 diabetes who have bariatric surgery find that their diabetes is cured—no medicine can compete with that. There is an argument from my colleagues that NHS Scotland is not offering enough bariatric surgery.

Dr Jamieson: To build on what Dr Bell said, the crux of the issue is that we will find the hallowed ground, so to speak—where we want to be with regard to explaining the benefits of the different ways that we can proceed with diabetes, for example—in shared decision making and the provision of good explanations to patients.

The guidelines are phenomenally important and supportive, but they can drive practitioners to do more things if they are not used correctly. I sit on behalf of the RCGP on the Scottish Intercollegiate Guidelines Network council, and the opening paragraphs of each guideline that we publish contain the caveat that a decision must be reached in the context of shared decision making with the patient.

We have to take the time to explain to patients, in a language that they can understand, the potential gains from medicines. We can show them the different ways that we can proceed with regard to weight management, whether that is operatively or through dietetic support and weight loss, notwithstanding the evidence void that currently exists with regard to the best ways to lose weight and to deliver HbA1c reductions. We have to be open and honest. With shared decision making and a patient-centred approach, we can deliver on some of the outcomes that we are trying to achieve. If a practitioner misunderstands the purpose of a guideline and is driven towards prescribing, they will potentially end up adding more and more medications without necessarily seeing the wider picture.

The Convener: There seems to be a view from some of the panel members that we need some method of ranking different inputs or ways of approaching a particular issue. Who should take the lead on that? Where should responsibility primarily lie?

Dr Jamieson: We are doing some of that work. Ann Wales, who works in e-health and digital for the Scottish Government, is doing some work to build into the consultation process shared decision aids to use with patients. There are a few examples worldwide of decision aids being used—the Mayo Clinic uses decision aids for diabetes and in respect of bisphosphonates for osteoporosis, for example—but the approach is still in its infancy and the picture is complex with regard to prescribing medicines.

We do not always have the tools readily available at the point of prescribing to enable us to show people the tangible numbers. I have an interest in therapeutics, and I am reasonably comfortable with most of the evidence for most of the common things that I do. Nonetheless, it is hard to get tangible evidence that is specific to a patient. With a multimorbid 85-year-old with five other diseases, for example, what are the caveats to the evidence that I need to present? It is really complicated and difficult to try to show that in an intelligent way that is accessible to me at the point of prescribing, and it is not yet being done. However, it needs to start somewhere, and we need to be taking that approach.

09:45

I am very much an advocate of the work that the Scottish Government is championing in that direction—on chronic pain, for example—to try to bring on those conversations, although the information is currently very binary and crude. For example, it quotes figures that might not be applicable to the patient in front of me, or it does not take into account that my patient is not the same as the type of patient in the studies on which it is based. That said, we need to start somewhere, and I am very supportive of the Scottish Government's moves in that direction.

The Convener: We have a couple of supplementaries, from Sandra White and Brian Whittle.

Sandra White (Glasgow Kelvin) (SNP): Good morning. The issue of alternatives to drugs and medicines is hugely important. Is a cultural change needed among the general public? We know that the deep-end GP practices guide people towards various other solutions; perhaps we need more of that.

Should there be a campaign by the Scottish Government or the national health service to let people know that there are alternatives to drugs? Sometimes people are on a drug and then they simply go on another drug. Would it be best to deal with the situation through community pharmacies and local health services? What are your thoughts on that?

David Coulson: What you are talking about is really important. It is equally important from a public health perspective that we encourage lifestyle changes and ensure that we have very well-informed and engaged patients in our communities, who are able to take part in conversations about realistic medicine. There have been public health campaigns about lifestyle choices such as diet and exercise, and about social isolation, to ensure that people in communities talk to one another. That work is essential. Community pharmacies have a central role in supporting many tenets of that approach, as do general practitioners and all prescribers. A national public health campaign based around all those elements would be very powerful for our communities.

Dr Bell: With regard to the different options that are available—non-medicine alternatives or even options within medicine—we have already referred to realistic medicine and the need for shared decision making. At the point of contact with a healthcare professional—although maybe it should happen elsewhere or beforehand—there is increasing use of patient decision aids that list all the different options and their risks and benefits, and in particular the number needed to treat, which I think is what Dr Jamieson was talking about.

That work has already started. In my diabetes practice, we use patient decision aids to allow patients to express their values and what is important to them in the context of the knowledge and evidence that is presented to them.

Brian Whittle (South Scotland) (Con): Good morning, panel. We have already touched on this issue. In just about every one of our committee sessions, no matter what the topic, the subject of data collection and the use of data seems to come to the fore. Today is no exception, given that we are looking at the measurement of patient outcomes with regard to prescribing.

Data is seen as a way to improve prescribing practices and assess real-world medicine. However, it is my understanding that, in Scotland, little data is collected on patient outcomes. We should be in a good position to do that, given that Scotland has a unique community health index number for every patient. How feasible is it for us to move to a system that routinely measures patient outcomes? Could that be linked to the care pathway? A more relevant question might be, how essential is it for patient care in the future that we go down that route?

Matt Barclay: That is a good question. As I have previously mentioned, as an end point for the supply of medicines—or non-medical interventions, as can often be the case—community pharmacy has a role to play as part of our public health service. Along with that role comes the question—Dr Bell touched on it earlier, along with the once-for-Scotland approach—of whether community pharmacy can feed into a single central record. At the minute, we cannot do so; we tend to capture things in isolation.

I am not just citing community pharmacy as one end point, however. We have good data on primary care, and it is used. There is the Scottish Therapeutics Utility application and there is PRISMS data for primary care around prescribing, for example—under the prescribing information system for Scotland. Those are well used, and they have been used in the past. However, supply data on what the patient comes into the pharmacy to pick up, on how they use it, on whether they use it appropriately and on adverse events are probably captured quite haphazardly throughout the system, and not in a routine way. That is definitely one area in which we can improve.

David Coulson: Outcomes are very challenging. It is quite easy to measure blood pressure and to understand the outcomes that we are trying to achieve there. It is a complex matter, however, to agree on the outcomes that we are trying to achieve, and some things are personal to different patients.

The data is very important for our system, and we understand, from a primary care perspective, that we have very good data sets on the use of medicines. That allows us to have conversations with prescribers in primary care about their practice. We do not have that situation across the whole of secondary care, however. We need a whole-system approach to prescribing rather than a focus on just one part of our profession.

There are 122 million administrations of medicines in our hospitals across Scotland. That is a ballpark figure that was in a Scottish Government paper a few years ago. We do not have a huge amount of data on that, but the programme that has been supported by the Government for the implementation of electronic prescribing and medicines administration will put us in a really positive place to understand the variation that might exist in practice, and to interrogate the data. That programme is really important, and it will allow us to join up the whole-system data.

Dr Jamieson: Some databases are used for exactly the purpose that has been described, and there are two or three common ones. I am not sure whether you have heard of the Clinical Practice Research Datalink, or CPRD. It is a collaborative between the Medicines and Healthcare products Regulatory Agency, the royal college and the National Institute for Health Research. CPRD taps into anonymised data from general practice in the UK and publishes a lot of really important stuff about what has happened to patients following interventions. That is slightly limited in that the data concerns heterogeneous groups: those concerned are not perfect patients, and we cannot correct for all the variables, but the data does include some important, enriching data for the evidence base. There are something like 2,400 publications just from CPRD data, which is UK general practice data.

The research is out there, although the work is done at the behest of those who wish to invest and do the research for the outcomes that they potentially wish to publish. NIHR is probably the best example of a publicly funded group in the UK that seeks to fund research on the questions that we want answered. Those could include something as simple as, "When does a GP know to prescribe an antibiotic for a chest infection?" I am not sure. What happens to the people concerned? How do we follow it up? Doing research to find evidence to answer such a simple question is not really attractive. We are at the behest of whoever wants to do the research, and that brings us back to the questions that were raised last week about cancer drugs. It is a question of what research you want to do for the outcomes that you want to show. That partly ties into how we fund research and what research we want to do. As I say, the research is out there.

That also ties into the previous question on social prescribing and non-medicines alternatives. We would strongly advocate continuing research to show the evidence base for those options. We need to show evidence for them that is as good as the evidence for the drug options, and we need to put as much investment into them so as to help our patients and to help our clinicians to make their decisions.

Brian Whittle: It seems, from all the evidence that we have gathered, that the move towards some sort of universal national system that is accessible to healthcare professionals is fairly compelling.

Moving on from what you have just said, where are we when it comes to gathering data across the country? How is that being directed, or are things patchy from health board to health board?

Dr Jamieson: Regarding prescribing and outcomes?

Brian Whittle: I am talking about the gathering of data to enable a more specific prescribing methodology.

Dr Jamieson: It comes down to publication bias. For example, at SIGN, when we generate a guideline to inform a pathway, we are shaped and slightly constrained at times by what people have evidenced and published. National guidelines are based on the evidence that has been published.

At the RCGP, the research paper of the year is a big part of our college conference, which is coming to Glasgow later this year, and the national support for that is very welcome. Talking informally with my colleagues in London about the research paper of the year, I suggested that there should be a research question of the year. What are the questions that are really bothering GPs about what we do not know? What are the things that we are really keen to know? Those questions are almost as important as the research that is being done.

What are the unanswered questions? Is that information being co-ordinated at a national level? I do not think that it is. Do we have good prescribing data in primary care? We do, as well as data interrogation at a local level.

In secondary care, as David Coulson has said, the situation is different. We are limited because much is still done manually, therefore the ability to interrogate it is a little more challenging. In primary care, however, we have really good data that we are able to assimilate. Speaking as a local prescribing lead, I can say that, when something very expensive and outwith the formulary is prescribed, I will know about that quite quickly, and I can discuss it with the people in the practice. We might agree that they had not realised what had happened. If they had realised, however, I might say that, if they had checked it and were happy with it, it would be absolutely right for that patient.

We are quite good at keeping on top of that in primary care. I cannot speak for my colleagues in secondary care, where I appreciate that there are a lot more challenges in getting those types of data.

Brian Whittle: Where are we with a data system that would allow that sort of cumulative evidence gathering for an individual patient whose case involves co-morbidity and multiple medical interventions? Could a better picture around that individual emerge from the cumulative gathering of evidence from, say, various 10-minute appointments with different healthcare professionals?

Dr Jamieson: The evidence base for multimorbid, real patients—for example, on diabetes interventions that I might want to pursue with a 90-year-old—is limited. I find those

conversations hard, but I fall back on realistic medicine. I explain those things to my patients. I tell them that I am sorry but that the evidence I am going to discuss is not based on them. They have to choose, for example, what they think they might gain from going on to a particular cholesterol-lowering medication. I can explain to them what the intended benefits are, but I cannot tell them what values they will observe in making their decision.

Notwithstanding the evidence shortfalls and the lack of work that has been done on that—although it is progressing, and we recognise as a community that the work needs to be done—I fall back on realistic medicine to help me, because I think that is a great doctrinal document that helps me to explain the limitations, not just be driven by what a guideline might say. A guideline informs those conversations, and the patients are getting more and more used to that.

My colleague Dr Carey Lunan, the chair of the RCGP Scotland, has had dialogue with the Cabinet Secretary for Health and Social Care about having a national conversation around realistic medicine and the use of best value in medicines. Having that doctrine—that ethos that we need to have such discussions with patients—makes things a lot easier. Falling back on the quality assurance framework—a tick-box approach that requires us to do certain things—really undermines that and makes things a lot more difficult. With the doctrine and the Government policy right, it is a lot easier for me to explain those uncertainties to patients and live in an uncertain world.

Matt Barclay: I emphasise what Scott Jamieson is saying. The advent of realistic medicine has been a real culture change for healthcare professionals. What used to happen was the optimisation of guidelines for patients. For example, if a patient had diabetes, x, y and z were wrong, so x, y and z were prescribed. Scott Jamieson eloquently describes the culture change that is feeding through the whole health system. When Scott has prescribed something and the patient comes into the pharmacy for the first time with that prescription, the conversation and the messages are reinforced—much more than was the case 10 years ago.

On your point around data, Mr Whittle, in community pharmacy, as you know, we do not have sight of any data. If the patient uses the same pharmacy regularly, we can capture much of that information through our computer systems and our medicines care and review service, but it tends to be siloed. There are great examples of good partnership working between community pharmacies and GPs up and down the land. Those relationships and prescribing habits are discussed—it just depends on the locality.

10:00

Emma Harper: I want to pursue a couple of questions around the single national formulary. I know that the 14 NHS boards have area drugs and therapeutic committees, which make decisions on which drugs should be prescribed by clinicians in their area. The Scottish Government has committed to producing a single national formulary in the once-for-Scotland approach, which was mentioned earlier. I am interested in what the panel thinks about that. I should say that Dr Bell is a former colleague of mine—we worked together at NHS Dumfries and Galloway.

There might be issues around data and data gathering, but that might also be a positive aspect of having a national formulary. There has been some criticism of the idea of creating a single formulary, because it might not meet local needs. I am interested in the panel's thoughts on that.

The Convener: That is your cue, Dr Bell.

Dr Bell: The SNF is a good idea in principle, but there has been a challenge in delivering on it. One of the challenges is how we define a single national formulary. Is it a list of drugs that is developed centrally? That might ensure consistency and less unwanted variation throughout the country, but it might also lead to a loss of ownership of local formulary decision making and might clinically disengage consultants, healthcare professionals and pharmacists, who develop the formularies locally. There are advantages in that there could be consistency and it would fit the once-for-Scotland approach, but there are also downsides.

Developing a list of drugs is one approach. Another approach, which would be more value-added, would be to develop intelligent national therapeutics pathways that were condition specific. For example, the pharmacotherapy pathway for type 2 diabetes was published a couple of years ago and is similar to the Scottish intercollegiate guidelines network guidance. That would be an agreed national pathway. There would be realistic medicine patient decision aids within that national pathway to ensure that patient values and what mattered to them were taken into account. There would also be some variation in the data across Scotland in some areas of type 2 diabetes prescribing. All of that exists, but it has not been pulled together. That would be a more value-added SNF.

The advantage of that approach would be that the local formulary decision-making processes would continue within the context of the national pathway, which would be groups of drugs rather

than specific drugs. That would allow local engagement and ownership to continue.

The Convener: That SNF would join things up rather than provide a replacement.

Dr Bell: It would bring together different strands into a national pathway.

Dr Jamieson: I sit on the local NHS Tayside ADTC medicines advisory group, so I am involved in the process of maintaining the local formulary. I echo Ewan Bell's comments in respect of my local NHS Tayside role in Angus health and social care partnership, where engagement with the formulary is really important in maintaining our ability to shape good care. The SNF has great potential to share information, what local formularies have looked at and the vast breadth of experience and expertise that are out there in shaping local formularies.

On my commitment to our local formulary, would I have the time and the ability to have the same commitment to a national formulary, were I lucky enough to be chosen to support that? I suspect that I would really struggle to have that at a national level.

At the moment, there are clinicians like me in every health board, who are really committed to finding the best things. When one area finds something that is useful or a more effective way of using something, we share that information in the local formularies.

Importantly—I am now speaking from my RCGP perspective—we also build pathways into formularies. The local pathways are really important, too. Knowing clinicians and how to access things locally, or how to manage dementia or a high-risk drug in our local area, is important. An SNF would not address that issue, but having that aligned to the medication insert in our formulary helps us at a local level to know how to use something in our area.

Greater Manchester, which has the same population as Scotland, has one formulary. That would be fine, but greater Manchester has the network and communication links in one small area whereas we are spread around a far bigger area and we have to deliver very different services depending on whether people live in Shetland or Benbecula or in Lothian or Tayside. Each area has had to develop and evolve its services. Therefore, how we use medicines and how we share care with our secondary care colleagues is different. It is not the same in every area: every level has different services to support that formulary, and it is all intertwined—it is not a distinct thing.

Is there still value in developing it in the way that Dr Bell is intimating? Absolutely. There is great shared learning and there are great shared pathways to be developed. I would love to have that platform. The issue is not that an SNF is not a positive thing. However, I would urge caution on the engagement front, as there are aspects of that that I would be wary of missing out on.

Emma Harper: A formulary can also be used for dressings and non-medicines such as Abbott's FreeStyle Libre glucose monitoring or continuous glucose monitoring. Would a national formulary help to connect knowledge gained from managing blood glucose levels of people with type 1 and even type 2 diabetes, who might be using some of the technology intermittently in order to obtain a better awareness of their own glycaemic control? Would a formulary support other non-medicine approaches, to help and support patients?

David Coulson: I will start on that question and then bring Scott Jamieson into the conversation.

You mention non-medicines and the prescribing of them across NHS Scotland. Locally, we have added significantly more governance around that, because we considered that there were opportunities to strengthen what we were doing, including through understanding the outcomes associated with some non-medicines in real-life settings. You mentioned FreeStyle Libre, and it is important to know whether that is delivering what we expected it to deliver on the basis of health technology assessments.

National governance that modernised the supply of non-medicines and a central list of non-medicines would be quite good.

Scott Jamieson has led some related work in Tayside. Perhaps he can take off his RCGP hat for a moment and put on his Tayside hat to describe some of that work.

Dr Jamieson: I looked at the top 70 or so items that we were spending on in my area, and the aspect that I really struggled with was the non-medicines, the prescribing of which was going up. I discussed the matter with my colleagues across primary and secondary care and in the specialist services, and the aspect on which we really needed to focus was not medicines. That was about three or four years ago.

You are right—everybody will know what a medicine is. That is the case for those who go to a pharmacy or a secondary care service and those who are admitted to hospital. However, not a lot of people ultimately understand specific types of non-medicine, be they dressings, stoma products, diabetes products or catheter products. For example, we have a very small number of colorectal specialist nurses in Tayside who are managing 1,500 stoma patients. When someone goes into hospital, those nurses can identify what medicine a patient is on and ask whether anyone has reviewed that recently. People naturally

understand medicines, but understanding non-medicines is far more difficult.

On the establishment of a national formulary for non-medicines, the bottom line of the prescribing of non-medicines advisory group that we have created in Tayside, which helps to assure and put governance behind all non-medicines prescribing in Tayside, is that we need to establish a good formulary process that helps to create a formulary that everybody recognises and that we can all work towards. Thereafter, there is a need to consider the review processes for the formulary and the people who use those non-medicines. The formulary is the starting point, and the reviewing and the governance that underpin it are the second point. Patients deserve to have as much time and attention spent on their non-medicines as is spent on their medicines.

It is an area of extremely high cost but without the regulatory supports that are in place for medicines. There is a lot of direct marketing to patients in that regard, which does not happen with medicines. This might be a surprise to members but, in the UK, direct marketing of prescribed medicines to patients is not allowed. If members have watched television in America, they might have seen adverts that do so. However, the situation with non-medicines is not the same here. Suppliers can directly supply samples to patients, but, if a patient asks their GP whether they can swap one item for another one that they think is better, the average GP does not have the expertise to answer that. There is not sufficient infrastructure for the 1,500 patients who might be using the items, so we must invest in that. I have been working a lot on the issue, with the support of my primary and secondary care colleagues, and it has been quite an undertaking.

I would have no problems whatsoever with a national formulary for non-medicines, with the governance delivered locally. At present, we are doing both. I know that, previously, when attempts have been made to create a national formulary for non-medicines, that has been a challenge. I am probably not best placed to discuss what happened in that regard, but it has been tried and it was challenging.

Dr Bell: I sit on the Scottish health technologies group, which makes recommendations to health boards on non-medicine technologies. There is definitely an opportunity regarding governance and formulary development for non-medicines. The way in which health boards throughout Scotland receive the recommendations for non-medicines from the Scottish health technologies group is probably not consistent—FreeStyle Libre is a good example of that. Therefore, there is certainly an opportunity to strengthen the governance of non-medicine technologies, but I do not know whether that should be at local, regional or—as Emma Harper suggests—national level.

The Convener: That has been helpful.

David Torrance (Kirkcaldy) (SNP): Prescribing accounts for 13.1 per cent of the total health budget. Where are the biggest opportunities for further curtailing the prescribing budget, and can the recent success in primary care be maintained and extended to secondary care?

The Convener: That is a hard one. Who would like to start?

Matt Barclay: I will give it a go.

The Convener: Matt Barclay is ever at the forefront when there is a hard question.

Matt Barclay: It is a good question.

That 13.1 per cent represents a huge amount of money. Obviously, under the new GP contract in Scotland, pharmacotherapy has meant that there has been Scottish Government investment in pharmacists becoming part of the general practice team. Their focus will be on cost-effective prescribing, adverse events and supporting GPs in the practice. As I have mentioned previously, from Community Pharmacy Scotland's perspective, there is a need to look at the medicines care review and, potentially, to contractualise that slightly better in order that we focus on a proper medicines review so that we have conversations with patients and record the outcomes. At present, we have the conversations, but we do not record the outcomes. Our doing so would allow us to cement our place.

In respect of long-term conditions and multimorbidity, pharmacists—as the experts on medicines—obviously like to take a view and to have conversations with patients about what is prescribed for them, how they are taking those medicines and whether they are taking them at all, as I mentioned earlier. In some instances, we know before the doctor knows when patients' prescribing and pick-up patterns change. There are opportunities to ensure that the realistic medicine conversation that Scott Jamieson talked about happens more frequently in community pharmacy.

We can play our role by looking at waste and optimisation, and we can do that by questioning whether people are taking their prescribed medications properly and getting the best benefit from them. As David Coulson mentioned, those are conversations that should be had, as part of a whole-system approach.

When I appeared in front of the committee last week, I said that the spend is huge but the trend in recent years has been that it is coming down slightly.

10:15

Dr Jamieson talked about having conversations about the approach to prescribing and about community pharmacy playing its part. It is about controlling cost. The cost of medicines should also be seen in terms of value, rather than in terms only of cost. When they are used appropriately, most medical interventions using medicines are perfectly good value for money. The situation has to be looked at in that light.

David Coulson: It is a very challenging question.

There are, in NHS Scotland, various supports for use of medicines. Last week, the committee heard from colleagues from NHS National Procurement. From a secondary care perspective, NHS National Procurement is key in helping to manage the cost of the medicines that come into our system. However, it is not only NHS National Procurement that is involved. The system also relies on the Scottish Medicines Consortium, for example, to ensure that evaluation of new medicines that come to market is robust. The SMC does a fantastic job on that.

We need to assure the value of new interventions by ensuring that the healthcare system will get something out of them, that patients will benefit from them and, as per the realistic medicine principles, that patients are being engaged in conversations about their healthcare. Various programmes of work to tackle the challenges in primary care are ongoing. It is a whole-system approach.

It is also about understanding the polypharmacy challenge. Why a patient is taking 10 medicines should be questioned; it might be absolutely fine for one patient but inappropriate for another. From community pharmacy, to pharmacies working in general practice, to nursing teams, we all have a responsibility for that, and for managing the pill burden and the value that we get from resources.

Dr Jamieson: I agree. We all see the challenge of the question and for each of us the question is pertinent.

From the RCGP's perspective, delivery of cost reduction comes through good conversations with patients. Not only should the cost effectiveness of medicines be considered, but patients should be asked what they think are the benefits of them and why they think they are taking them. If a patient does not know why they are taking a medicine or what its intended benefit is, that is a failure of the system. When we have time to ensure that realistic conversations are being had with patients, and the positives of taking their medicine are being explained to them, they will be more likely to value the medicines and take them.

I appreciate that this all relates to the committee's future conversation on wastage. I apologise because I cannot attend that meeting; my colleague Dr David Shackles will attend.

When patients know why they are taking a medicine and value it, and they know the benefit of taking it, they are more willing to take it. If they have to take it religiously because they have been told to do so, patients do not necessarily want to buy into that relationship, which means that they might not take the medicine.

On how to reduce prescribing expenditure, I say without my RCGP hat on that my focus locally in the coming 24 months will be on non-medicines. That is the biggest area in which governance and effective use can be improved, by ensuring that patients get the reviews that they are entitled to and should be getting, as they do with medicines. That is how we are tackling the matter locally. Although I am not speaking from an RCGP perspective on this, I note that being able to do that is very much to do with having the right conversations with patients and having enough GPs and time, supported admirably by community pharmacists and practice pharmacist colleagues. That is a cultural change that I have seen locally.

Speaking as a local prescribing lead, I point out that we have delivered effective changes in our prescribing patterns not by being punitive, but by having conversations with practices and clusters to discuss their prescribing patterns, to enable them and to value the time that they spend on tackling problems.

It is about changing the culture of prescribing and ensuring that we, as prescribers and as patients, question why something is being done. Those changes are far beyond the initial conversations: they have permeated through the entire system. I suspect that the reason why there has been a flattening and reduction in spend in the past three years is that the whole system has taken its time to invest. It is about understanding the harm that medicines can do to us, but it is also about valuing their benefits.

Dr Bell: There is a good news story. The ADTC collaborative, which sits within HIS, was responsible for developing a prescribing framework for moving patients from biologics to biosimilars. The framework tries to ensure consistency of approach throughout NHS Scotland, and has saved tens of millions of pounds. There is an opportunity, as biologics come to the end of their patents, to move patients from biologics to biosimilars that have the same effect.

There is a high rate of generic prescribing within NHS Scotland, and that needs continued vigilance. There are good things happening,

supported by stakeholders including the ADTC collaborative.

David Torrance: What role could hospital electronic prescribing and medicines administration—HEPMA—play in controlling hospital spend on medicines?

David Coulson: HEPMA plays a pivotal role in helping us to manage the challenge of secondary care prescribing in a very different way. We spoke earlier about not having any real prescribing data. We rely on small audits that are very manpower-heavy. HEPMA will give us a huge amount of data right down to prescriber level, just as we have in primary care. If we identify variation in practice, we can have a conversation with teams to understand why the variation exists, and to work towards a common pathway for certain conditions within secondary care.

HEPMA will allow us to share and understand the whole picture across hospitals in Scotland. We have the hospital medicines utilisation database, which is a useful tool, but it just gives us a high-level picture of spend. HEPMA will increase opportunities to use data in secondary care. It will give information to prescribers and medicines management teams so that they are accountable for what they spend. That is different from where we are now. HEPMA is a powerful tool, and clinical teams in Scotland value the commitment from the Government to support it financially.

George Adam (Paisley) (SNP): I want to follow on from what Scott Jamieson said about conversations with patients.

We often talk about empowering patients and making sure that they can self-manage, especially patients with long-term conditions. How could we empower people with long-term conditions to the extent that they could have that conversation with you, such that you suggest a way forward and they are informed enough to agree that way forward with you?

Dr Jamieson: That comes down to the whole system being in place. For long-term conditions, a lot of work is being done on the "Scotland's house of care" model, with which the Scottish Government has aligned itself. My diabetes colleagues work with the My Diabetes My Way website, which is a software tool to empower patients to have ownership of some of the markers of their diabetes control. We use tools like that for many other aspects of long-term healthcare.

We must be careful that the parameters that we put into such tools are evidence based, and we have to be clear with patients that some of those are surrogate markers; some of the tests that we put into the tools are not perfect. When we have conversations with patients about their cardiovascular risk, we can sometimes labour the data more than we ought to. We have to couch the conversation in the context of the patient.

As the data and software support get better, and as our ability to have those conversations improves, the data will become intelligent. I expect that, during my career, we will have artificial-intelligence interrogation of patients' bioparameters against what evidence says. We have some cardiovascular risk scores that take some patient parameters into account, but they certainly do not take account of everything that contributes to individual risks. I envisage that, within my GP career, I will be having much more informed conversations with patients about long-term care of their condition. That will come from continued investment at national level, as we get the new IT provision for GPs, which is on-going.

The tools to help us are not yet developed, but are being developed. Those conversations take time, but we very much welcome the investment and the right conversations being had with people with long-term conditions about their care and the benefits of their medicines.

Matt Barclay: As Scott Jamieson said, the question was really good. It encompasses issues relating to health inequalities and health literacy. How do we get the message across to patients? We mirror what they say to us, we use their language and we talk about things to which they can relate.

When I was doing a shift on Saturday, a smoking-cessation patient in his early 40s came into the practice. His main driver for quitting smoking was that he could not, when he was playing football with his son, run about and kick the ball so much any more. At the start of his journey, I emphasised the benefits that he would get from quitting smoking, and I hope that, when I go back in a few weeks for my next Saturday shift, he will still be coming in and I can ask him how he is getting on and whether he has been able to go out with his lad.

As well as the need for prescribers to have decision-making support tools, it is important to have relatable conversations with patients. It can be difficult to have such conversations in a short period, but we need to root them in real life.

Emma Harper: I have a couple of questions about disinvestment and medicine reviews.

In many general practices, we now have pharmacists who help with medicine reconciliation and with patients who have polypharmacy needs. How do we disinvest in meds that are perhaps not as effective, or for which there are effective alternatives? Our briefing paper talks about homoeopathy and herbal medicines, and older medicines that have not been reviewed in the same way as new meds have been. Some written

submissions say that it is perceived that it is particularly difficult to change prescribing for patients who have been on medicines for a long time. Is there a role for bodies such as HIS and the Scottish Medicines Consortium in identifying areas for disinvestment nationally?

Dr Bell: Yes, there is possibly a role for Healthcare Improvement Scotland in reviewing evidence. However, that will require health boards identifying areas for HIS to look at, and it would require disinvestment in healthcare infrastructure thereafter.

Dr Jamieson: Emma Harper has asked a valid question that reflects the work that our colleagues in NHS England have done explicitly on highlighting medicines that they think are of limited value. Disinvestment is a double-edged sword. In my conversations with patients, I rest on the evidence and I share the decision with them. I explain to them the benefits of a product or the limits of the evidence that exists.

To be honest, I do not have an opinion on whether we should have a list of things in which we should not invest. It is very difficult, emotive and challenging for patients to have such conversations. We might get a directive or a suggestion that we should not prescribe certain things, but we are left to have the conversation with the patient, who might say that the product is the right one for them, as an individual, and that they get a benefit from it. As a GP, I have had many such conversations.

In general, I rest on fairly sound evidence and health literacy, which Matt Barclay identified. I ensure that I have conversations with patients using language that they understand, and that I use the tools that are at my disposal. For example—I hope that I am on solid ground on this—given the evidence on omega 3, I hope that we can all agree that it probably should not be prescribed for improving cardiovascular outcomes in primary prevention. It has a role in stopping pancreatitis in certain subgroups of patients, but that is a different issue.

We all agree on that point but, even so, such conversations be challenging, and there are far more emotive drugs out there, which NHS England has chosen to consider. As a GP, I would find it quite restrictive to have lists of things that we could and could not prescribe. There would also be unintended consequences with regard to how the patient feels about that.

Furthermore, sometimes people—including members—come to us and say, “Guys, you are not prescribing this drug, but the patient feels the benefit of it.” I completely sympathise with that view. What would we need to do to accommodate that? We would need national backing, as we have in realistic medicine. Everybody would have to be in alignment, from the political and clinical perspectives.

10:30

Is how we manage patients in relation to realistic medicine the right way to go about things? I am not sure. However, as a GP, I am at the crunch point of that, so I would have a lot of sympathy with my GP colleagues around the country if we were working to prescriptive lists of things that we could and could not prescribe. France has taken a hard-line approach to some dementia drugs, which it does not allow to be prescribed. That is a hard thing to deal with when you are talking about something as emotive as dementia. I would be hesitant about adopting such an approach. Everyone would need to be aligned to it, and I am not sure that that would ever be the case.

Emma Harper: Warfarin is a drug that is relatively cheap, but people who are using it require to take time off work to get their blood drawn so that their blood levels can be checked, and it requires a phlebotomist’s time, laboratory time and so on. Do we need more information about the economics of warfarin versus its potential replacements? For example, the replacements might be more expensive, but they might not require the same process that is required when warfarin is used. That issue is raised with me by people now and again.

David Coulson: The principle that you describe is an important one to the NHS. We need to consider the whole-system cost of medicines, which involves the issues you mention, such as the phlebotomist’s time, lab time and the use of reagents, and not just the procurement cost. We need to take that considered approach to medicines to ensure that we are making the right choices. We must make decisions that are based on sound clinical evidence.

Emma Harper: Do we have data on how often repeat prescriptions are reviewed? It could be that alternatives might be more suitable, or perhaps people could be taken off their meds.

Dr Jamieson: I do not know whether we have data on that at a national level. In primary care, it is an expectation of long-term condition care that medicines are regularly reviewed. I can say with confidence that that happens. Is there always the time to have the conversations that we would value? I cannot speak for every colleague in Scotland, so I cannot say whether that is the case. Do I value the changes that my Scottish general practitioners committee colleagues have negotiated in the GMS contract to allow us to have those conversations? Yes, absolutely. I very much

welcome those opportunities, because things are becoming more complicated.

The QOF mandated the review of prescriptions—we had to do that—and the processes for long-term condition care still exist in practices, even though they have not been extracted in the way they were in the QOF. I am not endorsing the previous approach, as that was a restrictive way of doing things, but the point is that the reviews are still happening. Our community pharmacy colleagues are helping us with that, so it is happening not only from a clinical perspective but from a clinical and dispensing perspective, which is subtly different.

Matt Barclay: I agree. We could definitely play a role in solidifying that medication review and in having more proactive communication in the primary care team than there is currently. Our GP colleagues value having those conversations which, as I said, happen in many localities. We often talk about pharmacists working within GP practices, but a medication review can happen in the community pharmacy premises, too. As long as information is shared, the system as a whole benefits.

Emma Harper: I know that a lot of work is being done with community pharmacies and pharmacists in GP practices to review and minimise unnecessary repeat prescribing. Could anything additional to that be done?

Matt Barclay: There is just the one thing at the minute. There is an NHS-approved repeat prescribing system. It used to be the chronic medication service, but it is now called the medication care and review service. Many health boards are trying to improve the uptake of that service. It gives a feedback loop from community pharmacies to GPs on prescribing patterns and the pick-up of prescriptions. In some areas, it is successful and the partnership between the GP practices and the community pharmacies is strong and works well. However, in the majority of areas, it has not taken off quite as much.

From my perspective, efficiency in repeat prescribing is probably the area that we could still work on, so that a GP does not have to keep signing prescriptions because they can produce a prescription for up to 12 months for people with long-term conditions.

Emma Harper: I brought up the issue of over-the-counter meds at last week's meeting. People constantly say that you can buy paracetamol for 12p in the supermarket. I completely understand that you can prescribe paracetamol or ibuprofen to support people with long-term conditions or to support the reduction in the use of opiates. The NHS in England has adopted a policy of limiting prescriptions for over-the-counter meds for an array of health conditions. It spends around £136 million per year on prescribing meds that can be bought from a pharmacy or a supermarket. I am a bit uncomfortable about making mandatory rules to say that someone cannot have a particular prescription and they have to buy it at the pharmacy instead. Could we or should we adopt a similar policy in Scotland?

Dr Jamieson: I do not have a fixed opinion on that. You raise a valid point, because I see repeat prescriptions for seasonal allergies; a working 40-year-old, for example, may choose to get their antihistamines for seasonal rhinitis prescribed through the hay fever season or they may choose to buy their antihistamines over the counter. I do not have a strong opinion one way or t'other about which option a person might choose. They have come to me with a medical complaint that is a long-term condition. It is a chronic condition that can be extremely debilitating. Would we preclude them from having a medicine in any other realm? Absolutely not. They are as entitled to get a prescription as somebody who has another condition. Why should I say that they are not entitled to the medicine on a free prescription?

As a local prescribing lead, I have found that my spend on the drugs that are available over the counter has been radically reduced. I think that that is because prescriptions in Scotland are free at the point of receipt to the patient; I suspect that patients are having more of these realistic value conversations about why they are on particular medicines and what they are taking them for, along with polypharmacy reviews and the support of our wider multidisciplinary teams.

That reduced spend is potentially a curious unintended consequence of free prescriptions. I do not know that, but I am certainly not able to explain why I have seen a 20 to 25 per cent reduction in paracetamol use; it is absolutely not through GPs proactively telling patients that they cannot have paracetamol on prescription. I would be very disappointed if I ever heard of that happening and I do not think that it is. I think that the reduced spend is because of a culture change. Patients who feel that they want a prescription can absolutely have one. There are those who choose not to, for whatever reasons—health literacy, affordability or even quantity. Quite often, it comes down to a question of obtaining a certain quantity. I have no objections either way. Those are some of the issues that I would find it difficult to unpick.

Matt Barclay: I am glad that Scott Jamieson quoted that figure; I did not know that. I will have to look that up after this meeting. As we talked about earlier, this is partly to do with a shift in culture. That national conversation with the public includes the value of medicines and self-care. If people just have the common cold, for example,

they tend to pick up medicines when they are out doing a regular shop. If they come into a pharmacy and certainly if they go to a GP, it is about having that conversation and asking whether it is the appropriate place for them to be. People are probably tending not to go to the GP for common ailments. The stats that Scott Jamieson gave may be part of that culture change that is happening among the general public.

I would be reluctant for any clinician to receive a diktat saying that patients cannot have a particular prescription, as Scott Jamieson mentioned and as I think I also said at last week's meeting. I know that Emma Harper is not suggesting that. Giving the clinician the freedom to make the clinical decision that is in the best interests of the patient in front of them is always the right thing.

Emma Harper: The Community Pharmacy Scotland submission says that, if prescription charges were introduced, those charges would be

"a barrier to the health benefits medicines can provide".

If somebody is on multiple meds and has to pay for them, they might have to make a choice about what meds they could avoid taking when in fact they cannot avoid taking any of those meds, because they are what is preventing that person from having a stroke, for example.

Matt Barclay: That was the reality when there were charges. Colleagues in community pharmacy circles south of the border, where prescription charges are £9 an item now, have patients making decisions in front of them about medicines—I hope that they are not the type of medicines that you mention. However, there are patients who just cannot afford to access medicines when there is a charge. Taking the charges away and having these strong conversations has been a theme throughout the evidence today and I hope that they give the benefits that are required.

Alex Cole-Hamilton (Edinburgh Western) (LD): The written submissions that we have received have spoken of the relative robustness of the SMC and its appraisal process. However, some respondents felt that, beyond the SMC, scrutiny has been eroded somewhat by political interference and patient preference and expectation, as well as by the centralisation of some the processes.

Peer-approved clinical system tiers 1 and 2 were highlighted as an area of concern for area drug and therapeutics committees and directors of pharmacy. There was a feeling that they impose decisions on NHS boards without considering cost or affordability for a board. Has access to new medicines been widened at the expense of cost effectiveness?

Dr Bell: I will try to address some of the concerns regarding the PACS tier 2 national review panel, which the collaborative has responsibility for hosting. There was a fear when PACS tier 2 was introduced that the cost was not considered as part of the decision-making process. However, I have not seen any data since them to substantiate that fear. From the data that I have seen, I do not think that that fear has been realised.

Alex Cole-Hamilton: Would you say that more patients are getting access to a wider range of drugs than they did under the individual patient treatment request system?

Dr Bell: The Scottish Government has collected data from the health boards on the outcomes of the PACS tier 2 decisions at a local level and that data sits with the Scottish Government.

Alex Cole-Hamilton: So you do not have that data to hand.

Dr Bell: No.

Alex Cole-Hamilton: Finally, what impact is PACS tier 2 having on NHS board budgets? Do you have that data?

Dr Bell: No, sorry—I was trying to say that I do not know whether there is any evidence or data on that.

The Convener: That may be something that we can follow up separately.

Alex Cole-Hamilton: I have now asked three different panels that question and we keep being told that there is data but we have yet to see it. I think that it would be helpful to the inquiry if we could get that data.

The Convener: It seems to be an opportune moment to pursue that and we will do that after this session.

Miles Briggs (Lothian) (Con): I have some questions on the non-controversial issue of the pricing of drugs. Specifically, do the panel members feel that the voluntary price regulation scheme is serving NHS Scotland well?

Matt Barclay: Certainly, with the voluntary pricing and access scheme, any growth in spending over 2 per cent is reinvested in new medicines—that is the specific purpose that the Scottish Government uses that money for. That probably speaks partly to your colleague's question as well. If the money is used appropriately, I would say that it is probably working. The fact that the cost of branded medicines is capped by the industry in that way gives that assurance that the cost is being controlled, and then anything above that level of growth is reinvested. It is probably for the committee to consider whether the reinvestment of

that additional money in new medicines is the best use of the money. I do not know whether there is evidence from others on how that money has been targeted or focused.

10:45

At a UK level and a Scottish level, the voluntary pricing and access scheme as introduced seems to work. From all the evidence that I have read, it does what it says it will do in terms of controlling costs and reinvesting in other areas.

Miles Briggs: The committee heard last week from the Association of the British Pharmaceutical Industry that there is a rebate of £70 million, which is going into the new medicines fund. Health boards have given evidence to the committee that that amount is not meeting the real-world costs of providing those medicines. David Coulson, do you think that the new medicines fund is properly recompensing health boards?

David Coulson: There is a challenge with the affordability of new medicines that are coming to the market. Through our horizon scanning, we know that some very effective medicines are coming but with very high prices. Acquisition costs are high. That is why we rely on the SMC to do those assessments and inform us that an investment is worth while.

I am not sure that I have anything to add on that question. Every health board is challenged by the affordability of medicines, primarily in secondary care. It is an area that we all keep a very close eye on.

Miles Briggs: We want to ensure that our work focuses on future-proofing the system in that specific area as well. We know what is coming down the road in terms of drug costs, particularly with the great new genetic treatments available to patients. Now that we have seen different systems, such as the cancer drug fund in England and the new medicines fund in Scotland, what are the panel's opinions on how we future-proof that side of what are going to be very expensive future treatment pathways?

Dr Jamieson: There is the emotive, patient-related bit of it as well. There are some extremely expensive but, in some regards, extremely niche products, which are absolutely the right choice for some patients. I defer to the expertise on the panel but, as a generalist, I wonder whether all of us, including the committee, feel confident that—given the Montgomery report, the process for approval of medicines by the SMC and the parameters that we use to approve such medicines—there will be enough checks and balances in place for when there is an early access scheme or the release of a new medicine. Do we think that those processes measure outcomes that matter to patients, which I would say are quantity and quality of life? I am not sure that they do.

In my generalist's reading of it, I think about the things that matter to patients. I like hard outcomes that really matter. That is not necessarily what the evidence for a lot of the emerging medicines looks at. I can understand why that might be; if we were talking about future-proofing and trying to guard against exponential spend on something that is—as I suspect Miles Briggs was inferring—potentially without gain to the patient, I would turn to my colleagues at the SMC and say that, as we release a new medicine or give early access to this or that niche thing, we need to tie into that checks of what happens to the patients and then follow them up robustly. What is the quality of life and what is the change? If it is the right medicine, we want the data to back it up and help support its use, but if it is not—if we should not be spending that amount of money on that kind of medicine—what are we doing about it?

Given the amount of medicines that we are reviewing, I am not sure that our current way is at the level that we want it to be in those respects. Our submission to the committee cited evidence in that regard, and American data was published in *Prescrire* this month that cited similar and other concerns.

It is what matters to the patients. We need to follow that up. If a medicine is working, we champion it; if it is not working, we do not. What if it is shortening life—are we keeping a close eye on that? Those are the sorts of questions that I, as a generalist, consider. However, I of course defer to the expertise of my colleagues.

David Coulson: Scott Jamieson is right that we have to consider the associated outcomes. However, I note that the networks that we already have in NHS Scotland are very effective. We keep coming back to the SMC, which does some very good horizon-scanning work, so some of these things should not be a surprise to us. It is important that we discuss what is coming so that we know what is around the corner. We have had those conversations with finance and with the Scottish Government so that we can address affordability going forward; again, it all comes back to having a solid evidence base so that we understand that we will get value from those medicines. I hope that that offers some assurance about how the system operates right now.

Monica Lennon: I am playing catch-up, because I have not been part of the inquiry so far. I was struck by what the submissions to the committee inquiry have said on the issue of waste. I know that some of the background reports are now quite old. There was a study in England in 2010, which was followed up by a study by Audit

Scotland in 2013. At that time, boards were asked about the main causes of waste, including repeat prescribing, overordering by patients, medicines in care homes, the abolition of prescription charges and patients being prescribed multiple drugs. However, witnesses, including through their submissions, are still saying that we need to get a better understanding of the main causes of waste before we can properly address them. Do we have enough information about and understanding of what is causing and driving waste? What should the solutions be?

Dr Jamieson: It is nice to see you again, Monica. That is a really good question. Given the tonnes of waste that get returned to my community pharmacy colleagues, I would love to see a study that takes the time to ask what happens in that regard.

A lot of factors cause waste. I suspect that the reasons why a patient returns prescribed drugs depend on the patient, and include lack of efficacy or intolerance. I am very careful about some of the medicines that we hand out, and we change our default quantities carefully in the practice. If a medicine will not be tolerated very well, we will give only a small quantity of it. However, we cannot do that all the time, because the patient will contact us after two days to tell us that it has been really effective and that they need more of it.

I am sure that our community pharmacy colleagues are more informed than I am when it comes to understanding why we have tonnes of waste coming back. I am not aware of published data that quantifies all the different attributes and, from there, sets out what we can do to tackle waste. I think that that issue is coming up at a future committee meeting, which I very much welcome. That would help to inform you about why we prescribe medicine in the first place and enable you to ask about what conversations are had at the point of prescribing in order to try to prevent waste from occurring in the first place.

Matt Barclay: The reasons for waste in the system are multifactorial. Although there will always be an element of waste in the system, the issue is targeting the avoidable waste. For example, we cannot often predict an adverse effect on an individual or patient. GP colleagues with whom I have been fortunate enough to work closely tend to prescribe initial quantities in moderation—for 28 days, for example—so that they can see how the patient reacts. The point at which new medicines come into community pharmacy is often the time when a community pharmacist should make an intervention to reinforce the messages that the patient has already had, to make sure that they are well informed, that they know why—and are behind the reasons why—they have been given the medicine, and they are willing to use it as prescribed, because a patient not doing so is often one of the reasons for waste.

There are definite areas on which we can focus. NHS Tayside has a really good model, which was cited in our professional body's report on care homes. Waste in care homes is certainly an area that we can focus on. Another area is having better conversations with patients, including asking why they are returning medicines. As Scott Jamieson rightly said, community pharmacy gets medicines returned to it. It is a question of capturing data at that point, so that we can get a better idea of why they are being returned. We can certainly look at a few areas across the board on that issue.

David Coulson: Matt Barclay has stolen my thunder a little by discussing the work that the team did with care homes, which I was going to mention. That work involved not just pharmacy but the whole system working together to tackle the challenge. I am more than happy to share the report with the committee after the meeting to provide a little more detail.

As we have said throughout the session, a lot of what we are discussing comes down to the need for well-informed and empowered patients, and we need to look at how we educate our communities in order to achieve that. In NHS Tayside, there is a fantastic piece of on-going work in relation to our prescribing strategy. That is one of the key areas in which the team is working with communities to develop the concept of the well-informed, engaged and empowered patient. It is also a key element in a lot of the conversations about waste.

Monica Lennon: You described the work that is taking place in Tayside. Is that approach being rolled out in other health boards?

David Coulson: Are you referring to the care home work?

Monica Lennon: Yes, and the work on your prescribing strategy.

David Coulson: Each health board in Scotland has a prescribing strategy. At this time, we are not sighted on the commonality across those strategies. Again, I am happy to share our strategy with the committee so that you have sight of it.

Dr Bell: That is one of the advantages of the ADTC collaborative, which allows us to share good learning. I invite David Coulson to come along to the collaborative's next meeting to present to the rest of Scotland the work that is being done in Tayside.

The Convener: Our committee meetings are useful in many ways.

Monica Lennon: The 2013 Audit Scotland report, "Prescribing in general practice in Scotland", which was published following consultation with health boards, identified a knowledge gap. From the submissions that the committee has received, it seems that that gap still exists. People seem to have a feel for what is driving some of the waste, but we have not captured that in data, to get a national picture. If we do not know what is driving the issue, we do not know how to solve it. Can you suggest any solutions?

Dr Jamieson: I would seek to identify the variance in that wastage. I would look at different health board areas and at locality level across Scotland. If I saw that an area had a particularly low level of waste, I would look at what the board had done and ask questions about that. We did that with non-medicines and that is what we do with prescribing: we look at the areas that are doing well and we look at the different practices. For example, I might contact practices that are reducing their prescribing of opioids in an area to ask, "What did you guys do?"

I can see the data that has been published—the national therapeutic indicators are now a phenomenal public resource for prescribing data on every practice in Scotland. They are a wonderful way to enable us to see what our colleagues are doing, in order not to be critical but to learn from them about what they are doing or changing. I work with Alpana Mair, who is head of the effective prescribing branch at the Scottish Government, to help support that work. It has been a great way to share good learning. I would aim to share learning on what areas are doing to reduce their wastage and identify the variance within that, because I am sure that it exists.

Monica Lennon: I am happy to leave that issue there and move on to the issue of access to unlicensed medications. There is sometimes a lot of misunderstanding about what we mean by that term. People—thyroid patients, for example—are getting in touch with MSPs individually to ask about medical cannabis, and we are hearing a lot of unease among clinicians about a product that is unlicensed in the UK.

Last week, a number of us sat around the table with the chief medical officer and the chief pharmacist and heard about unlicensed medication in some fields of medicine. The CMO, Dr Catherine Calderwood, who is from an obstetrics background, told us that the majority of the medicines that she had to prescribe were unlicensed. There seems to be a bit of a funny picture across the country. Is there enough guidance in place on unlicensed medications?

David Coulson: That is another complex area. We need to be very clear that there are differences in terminology. We understand that a licensed medicine will have been reviewed and we are assured of its safety when it comes to market; that is the MHRA's role.

We see a lot of clinical conditions—paediatrics is a good example of this—being treated with medicines that have had limited clinical trials before they come to market. They are not licensed, but they have gone through that licensing programme for other indications. We are assured of the quality of the product. The MHRA terms that "off-label prescribing". It means that we have a medicine that has been licensed through our regulatory body, but the prescriber is not using it for that particular indication.

11:00

The risk of prescribing those medicines is therefore slightly less than the risk of prescribing an unlicensed medicine that might not have been manufactured in a facility that the MHRA has reviewed and of whose quality we are unsure when it comes to market. In addition, the medicine might not have a licence indication from within the European Union. At that point, the risk regarding the quality of that product transfers to the prescriber and to the pharmacist. That is a very different situation and why we need to be cautious about the use of unlicensed medicines as opposed to the off-label prescribing of medicines.

Matt Barclay: When we receive an unlicensed medicine in a community pharmacy from a prescriber, we, alongside our health board colleagues, have to follow clear protocols and guidelines to get authorisation to obtain the medicine. Those systems have been in place for four or five years, with patient safety and cost firmly in mind.

From a community pharmacy point of view, we certainly have in place protocols and procedures in place. It is quite often at that point that a conversation will take place with the prescriber. We ask whether they are aware that the product is unlicensed. Most of the time, they are aware. We then get a bit more detail from them about the product for the patient. That is how the situation has changed in the past few years—that is certainly my experience in primary care.

Dr Jamieson: Prescribers are pretty clear about unlicensed medications. The General Medical Council also has clear guidelines about the explanations that are required to be given to the patient about the risks that might be involved, as David Coulson nicely outlined when he spoke about what happens with an unlicensed medication.

On the off-label prescribing issue, my point is slightly different, though. Where there is a licensed

medicine for an indication, the guidance states that I should use it for that indication. If I did not use it for that indication, I would need to justify, on an individual patient basis, why I preferred not to do so, even if the licensing was not based on efficacy. For example, I have drug A, which is licensed because the drug company has gone to the expense of getting it through licensing for a specific indication. There is also drug B, which is also licensed and we know about its safety because it is made in the UK or Europe, but the company that makes it has not gone to the bother of getting it licensed for that specific indication. Let us say that the clinical trials have shown that drug B is twice or three times as effective as drug A and it is half the price. Under the current rules, we should use the licensed preparation, even if it is potentially less efficacious and 10 times more expensive than an alternative. That is where the individual clinician has to apply their judgment about the individual patient.

That is sometimes the difficulty that we have in a formulary—we are slightly tied to the rules and regulations that we work to. That is the crux of the problem and the difficulty. It means that I have to explain to individual patients that there is a licensed preparation and one that is not licensed for their indication. I have to explain that, although the latter is still a medicine and we might use it for something else—it might be a relative or sister drug—it is not licensed for that specific indication.

That situation applies to a lot of older drugs, because that licensing will never change. We have a lot of drugs for hypertension, for example, which might be licensed only for heart failure, but they are sister drugs and we know that, based on real-world data, they are as efficacious for hypertension. However, strictly speaking, we should not use such a drug, even if it is cheaper. That said, we apply a lot of judgment about using certain drugs in areas such as paediatrics and obstetrics. We need to do that because the data and licensing are not there.

Monica Lennon: Do we have the right processes to get the best outcomes for patients, or do we need more guidance and flexibility?

David Coulson: Our systems are effective. We recognise the challenge of unlicensed and off-label prescribing, but, in terms of licensed medicines and cost-effective prescribing, the system works well.

Sandra White: I have a question about the role of pharmacists, which I know we have discussed previously. Before I get to that, I have a question about the submission from Community Pharmacy Scotland. Something that really stood out was the point about pharmacotherapy—I hope that I have pronounced that correctly—and the role introduced by the GMS contract. The submission suggests that, because more pharmacists are employed by the health boards in hospitals and so on, it has

> "led to the unintended consequence of creating recent workforce issues as pharmacists and technicians have left"

community pharmacy. Could you expand on that? Does it mean that we are losing community pharmacists to the NHS and so we need to train more of them?

Matt Barclay: The GMS contract, and pharmacotherapy in particular, offers greater recognition of the role that the profession can play in medicines management and helping patients to get the best out of medicines. It has created practice pharmacists, which is a new plank in our profession. There have always been pharmacists in practices, but the investment means that every practice will have access to a pharmacist in a set time within the GP contract requirements.

We have a finite amount of professionals working in pharmacy, so the issue is where those pharmacists come from. They will come either from the secondary care setting or from other primary care settings, such as community pharmacy. They are shiny new roles in the profession and that makes them attractive—if it 15 or so years ago, I might have looked at it the job and thought, "That looks like a great role". Many in our profession have moved into those roles, which has had unintended consequences for our workforce.

In the past couple of years, the chief pharmaceutical officer has led workforce exercises to get a handle on workforce numbers in pharmacy. There is an increased number of pre-registration places and the universities are being asked to do a bit more as well. The numbers will probably not be enough.

Pharmacy is willing to play a role, and there are models other than community pharmacy. However, rather than the pharmacist necessarily being in the practice, if we had better communication, community pharmacy could play a role alongside our GP partners, from within the pharmacy practice. That is my main point. We are having discussions in a month or two with our SGPC colleagues on what that might look like. GPs are aware of the pressure that has been placed on community pharmacy and others and we are coming around to having, I hope, constructive discussions on different models.

I always thought that the new role being created in practices was a great opportunity not just for the profession, but as a conduit into practices. Having a pharmacist in a GP practice should be an amazing advocate for what community pharmacy can offer and vice versa. There are huge positives,

but we just have to be mindful of the consequences.

David Coulson: I agree entirely. The pharmacotherapy element of the new GMS contract has presented many exciting opportunities for pharmacists and pharmacy technicians. That presents individual health boards with a workforce challenge and there is recognition that effective workforce planning needs to be put in place.

The pharmacotherapy element links up the whole system and the role for community pharmacy is very clear. It is an area that we should watch with excitement.

Dr Jamieson: I strongly advocate the work of my practice administrative staff collaboration colleagues at HIS. We are doing quality improvement work in pharmacotherapy across Scotland and I will be attending the first event on Thursday. It is a national piece of work, and a significant proportion of Scottish practices have joined us to ensure that our pharmacotherapy services are delivering the most effective models. It is not just about the people, but is about how we use those people in the systems.

Every practice has a unique way of managing its medicines. We welcome the opportunity to improve our systems and learn from each other. HIS is championing that work through the quality improvement faculty. I am really looking forward to attending that event on Thursday at the Crowne Plaza in Glasgow, which should be good.

Sandra White: You are a very busy person, Dr Jamieson. It is a good idea. I am pleased that pharmacists and technicians are being recognised. I am keen to find out whether we are losing community pharmacists, which is my concern.

My question is not about your wish list, as such; it is probably about the things that have already been mentioned. I will come straight to it: what key changes are needed to enable pharmacists to operate at the top of their licence in terms of prescribing, reviewing medications and substituting branded drugs with generics and biosimilars?

Matt Barclay: Yes, I have mentioned that issue a few times. First and foremost is the need for access to records. We have a memorandum of understanding between the GP community and the health boards, so joint responsibility for that is in place, and it is now for health boards to work in their local areas. In Tayside, there has been access to the clinical portal for community pharmacies for a couple of years now. There are things that we can learn from some of the pilot projects that have been done.

I have said things about decision support tools, and we could have more information about benchmarking information for community pharmacy, which would be useful in certain cases. There is probably a longer wish list.

Sandra White: I could read them all out. Will I read them out and you can say yes or no? [*Laughter*.]

The Convener: Thank you very much, Sandra, but it is for the witnesses to give their own evidence.

Sandra White: Okay.

The Convener: I thank all our witnesses. It has been a very full session and we have heard a lot of good evidence. Several of you have offered to give us additional information to help our inquiry and we would certainly welcome that.

11:12

Meeting suspended.

11:15

On resuming—

The Convener: We will now take evidence on prescribing from our second panel. I welcome to the committee Eileen McKenna, associate director for professional practice at the Royal College of Nursing Scotland; Jonathan Burton, chair of the Scottish pharmacy board of the Royal Pharmaceutical Society in Scotland; and Dr Lewis Morrison, chair of the British Medical Association in Scotland.

In order to set the scene about the choices that are available, I will start by asking the same general questions about alternatives to medicines and prescribed drugs that I asked at the beginning of the session with the previous panel. Is prescribing sometimes used to plug the gaps that are created by a lack of alternatives? What conditions would benefit most from non-pharmaceutical alternatives? Is there more that we could do to utilise the wider healthcare team, rather than always going down the pharmaceutical path?

Dr Lewis Morrison (British Medical Association): This issue emphasises the complexity of what I do as a geriatrician. Focusing on prescribing and drugs, I view part of my job as trying to save as much of my salary as I can by deprescribing. That is a slightly facetious way of putting it.

Among the things that have an impact on the frail, multimorbid patients whom increasingly I and GP colleagues look after, access to physical therapies is key. In the context of non-medicines

prescribing, there is often a focus on prevention and risk reduction, but, if we are looking at maximising the health of individuals, my impact is often minimal compared to the impact of the wider multidisciplinary and community teams that keep people healthy and at home. That strays a lot outwith what we are discussing today, but, if you want to know what the evidence base suggests for what to do with 85-plus-year-olds who are starting to struggle, it is probably to keep them away from medicines and doctors.

There is an important point to make about access to wider health resources, which is dependent on people—in which I include not just patients but healthcare professionals—knowing that such resources exist. Particularly in the context of health and social care integration, it also relies on information being accurate and up to date, as a lot of those resources seem to change every six months, so they are difficult to keep tabs on.

That probably opens up your questions, rather than answering them completely.

The Convener: That is helpful.

Eileen McKenna (Royal College of Nursing Scotland): There has been a long history of multidisciplinary, multiprofessional teams being wrapped around individuals, which has allowed exploration of non-pharmaceutical interventions. Examples of that are found in cardiac rehabilitation, for example, where specialist nursing teams and allied health professionals are involved in long-term condition management and promote health and wellbeing rather than relying on pharmaceutical interventions.

Jonathan Burton (Royal Pharmaceutical Society): Prescribing can be incredibly complex, but it is fair to say that it can also sometimes be an easy option. If we are going to have a discussion about prescribing, I agree that we also need to have a discussion about deprescribing—stopping medicines in a caring, sensitive and appropriate way, which is quite often difficult—and my personal favourite, which is not prescribing at all.

I work in community pharmacy practice and I see a big part of my role as being a first port of call for patients and not only giving them timely access to some basic medicines that may be required, but teaching them how to self-care appropriately and supporting them in that process.

In Scotland, we are just about to go through the latest evolution of the patient-facing walk-in component of our community pharmacy contract, which has been badged “pharmacy first”. We will be expanding that service to the whole population, rather than just those who were subject to the previous prescription exemption criteria. That is a fantastic opportunity, but it brings with it challenges. We should not be overmedicalising minor and common ailments; we should be there to help patients navigate through the times when they feel ill or poorly, and give them the tools to effectively manage minor illness and look after themselves and their families in the future. That may involve brief interventions from pharmacies and GP practices, but we need to be mindful that one of our rules is to teach people how to look after themselves.

The Convener: Is there, or should there be, the same level of scrutiny for non-pharmaceutical interventions as there is for pharmaceutical interventions?

Jonathan Burton: Absolutely. We need to build the evidence base in that area. There are pharmacy-based interventions that we have been providing for a number of years, such as in the majority of smoking cessation attempts in Scotland, that involve the use of some licensed medications, but hopefully only for a short period and for a massive on-going benefit.

Pharmacies are part of the fabric of communities, as are GP practices, so we really need to support them as a resource and lean on them more. If we want people to follow self-care advice, listen to us and take actions on the basis of our recommendations about exercise, diet, and lifestyle changes, a lot of it will be about trust, which involves getting to know patients and their families. Therefore, we must never undervalue the importance of being in people’s communities, knowing them well and building that trust.

Dr Morrison: In effect, you are asking about the evidence for non-pharmacological treatments. Forgive me, but I will channel the bit of my career that involved doing research and academic work. In the context of chronic disease management, the frail elderly consume a large percentage of health and social care resources—and rightly so. One difficulty in providing the evidence for, say, physiotherapy for advanced Parkinson’s disease—to pick an example that I know about personally—is that there is a difference between trying to prove that a treatment cures or vastly improves something and trying to prove that interventions ameliorate the progression of something that inevitably will progress. For example, I know from my limited time doing research that the actual number of people whom you have to study to prove that what you are doing works makes doing so very difficult in some non-pharmacological areas.

If we apply the same standards, there is a real risk that we would never approve lots of non-pharmacological therapies, which are often physical, because we could probably spend the thick end of 200 years studying them before we knew whether they were actually attenuating or

ameliorating an inevitable deterioration in the case of people who have multiple chronic incurable diseases. The difficulty is that we have to fall back on the multidisciplinary professional view of whether such therapies are effective. We need to be really careful that we are not trying to apply a standard that we could never meet, because that would mean that we would never do certain things. That is a long-winded "maybe" answer to your question, but we need to be cautious as to how we approach the issue.

Monica Lennon: I want to pick up on avoidable medicines wastage, which we discussed with the previous panel. What do you see as the main causes of waste at the point of prescription?

Jonathan Burton: I will answer that question, as somebody who has had handed back to him a lot of bags full of medicines that have been partially taken or not taken at all. I agree with the general sentiment of the previous panel that this is an extremely complex matter. Sometimes it happens because treatments are not working, sometimes it is because of side effects, and sometimes it is because of other unavoidable circumstances in a person's life. As health professionals, we need to take a step back and consider whether we are missing opportunities to have good conversations with patients about how they are getting on with their medicines. It is a fairly straightforward question, but it can lead to some interesting conversations.

One of the key things in our written submission involved the concept of creating time to properly care for people, to look after them and to ensure that they are managing their medicines well and are not receiving medicines that they do not need. Sometimes, patients are embarrassed or ashamed to admit to health professionals that they are not taking the medicines that we have encouraged them to take and have prescribed for them. If health professionals spend more time with their patients and build trust with them, however, those conversations can become a little easier.

Pharmacies have a lot to offer in this area, and we could fix many of those problems. We will never get rid of medicines waste completely, but we can help to minimise it. Our general practice pharmacist colleagues are well placed to do some more detailed and well-placed polypharmacy reviews, dealing with some of the more complex cases and working shoulder to shoulder with our GP colleagues.

In community pharmacy practice, I see our role as involving effective, brief interventions. To give an example, we have two master of pharmacy undergraduate students from the school of pharmacy at the University of Strathclyde working with our pharmacy, looking into a brief asthma intervention. We have been running that for the past two months. My patient base consists of 17 to 25-year-olds, we are on a university campus and we have many asthmatics. We have done about 100 questionnaire-based and brief verbal intervention exercises, and about 80 per cent of them have revealed issues with the patient's treatments. Patients are too symptomatic—they are living with their asthma symptoms—there are things about their inhalers that they do not know, and they are slipping through the net. Taking the opportunity to have those additional conversations has unearthed much of that.

At the moment, we need to write that down on paper, and we need to figure out a way of sharing that with our asthma nurse and GP colleagues. That should form part of the IT that I am working with; I should be feeding back that sort of information routinely. We speak a lot about access to records, which is important, but one aspect of access to records involves giving health professionals, be they district nurses or community pharmacists, the ability to share back what we are revealing in our communities about what patients are and are not doing with their medicines and their conditions.

That paints a picture from a generally healthy, well-educated population without co-morbidities or polypharmacy issues.

Eileen McKenna: I support that point, and the emphasis on multidisciplinary team reviews. Everyone has a role to play. District nurses go to people's houses and can feed back. You have heard about polypharmacy reviews, and the point is to have a multiprofessional review.

There is an issue with time: many professionals are time constrained. There is some evidence of nurse prescribers having longer appointment times, promoting non-medicine interventions, doing reviews and listening to individuals with regard to their compliance and whether they take their medicines. That is multifactorial: as you have heard, it is about multidisciplinary reviews, polypharmacy reviews, people having time and patients being empowered.

The Convener: We have a couple of supplementaries arising from those last two or three questions.

11:30

Brian Whittle: Going back to the convener's line of questioning, do we need to change patient culture in terms of expectations around prescribing and medication? We have talked about the social prescribing element and about interventions by other healthcare professionals, such as physiotherapy for musculoskeletal conditions. Do patients expect some kind of medical intervention

when they go to the GP? Is there disappointment when that does not happen?

Dr Morrison: I almost came in on the last question about culture because it probably explains, in a nutshell, a lot of why there is dysfunction in the way that we practice in healthcare. We try to meet patients' expectations and concerns, but that sometimes causes friction with regard to what we, as healthcare professionals, know is likely to be effective.

We have to build it from the bottom up. In my career, I have observed a bit of disappointment, particularly around medication. Medication literacy in the populations that I deal with has not changed much over time. To boil things right down, when you are sitting in clinic going through the list of medicines that someone is on and checking their understanding, which might be, "Well, it's the little white one with the score across it, doctor", and what they take it for, which might be, "Well, I take it because I was told to," it makes you ask why we are in this situation.

In some other countries, particularly European ones, the level of knowledge and expertise that patients have about their disease management and medications is clearly far better than it is in this country. We are starting from a position in which people do not really understand why they are doing what they are doing, and the reasons for that are multifactorial. There are as many different reasons for that between individual patients as there are between healthcare professionals; it is easy to say that the treatment was not properly explained to the patient.

There is huge bunch of evidence about how to impart knowledge and get it to stick, but a problem is that we now have very data-heavy consultations. We are expected to bombard our patients with statistics about the risk of this and the benefit of that. To be honest, as a geriatrician, I try to move away from that approach, because I know that people would just be hearing a lot of words, and what matters is the impact. We are not necessarily in the best place that we could be in terms of the public's understanding of the purpose of treatments. They tend to focus on medication because it is quick: they go in, get a prescription, go to the pharmacy and get something.

The next bit of that story, which comes back to Monica Lennon's question about wastage, is that the public are polite. If we prescribe something to them, they do not want to tell anyone that they did not take it, because that will look a bit rude. I know that I am boiling this down to real basics, but that is what we are talking about. First, we must allow members of the Scottish public to have a conversation with healthcare professionals that does not end up with a prescription. Secondly, if it does end up with a prescription and they choose not to take the medication for whatever reason—whether that is because of poor understanding, or because the medication is not working or making them feel worse—they must be able to feel that they can go back and say that they are not taking it any more without being a perceived as a bad person or getting a row.

That is very woolly answer to your question, but it all starts with education. We have a lot of work to do to bring patients and the public with us over what it is that we are trying to do.

Finally, a lot was said in the previous evidence session about realistic medicine. Interestingly, the patient population that I look after, who are very frail and elderly, are pretty realistic. The hardest conversations that I have are often with the families of those elderly patients, who perceive medications rationalisation as being used to save money because old people do not deserve medication any more. Somehow, the message has got out that we are saving money by taking medication off people. That is not, of course, why I try to do it. There must, therefore, be some public messaging about the change in slant in what we are doing. It is about trust, ultimately.

Alex Cole-Hamilton: I have been hanging on every word that our witnesses have spoken. My question follows on nicely from Brian Whittle's. It is about culture and education—not only of the public, but of clinicians.

I have a constituent in her 80s who has multiple co-morbidities, many of which are caused by her sedentary lifestyle, which is caused by the fact that she cannot access regular and accurate chiropody. Her feet are in a mess, and she is in discomfort and pain. When you talk about polypharmacy, she is a case in point; she told me the great number of medicines that she is on.

How do we address the disconnect? How do we make it clear that there is a seamless pathway for people such as my constituent, who could be helped by a basic physical intervention that is not medical? How do we make that something that everyone can access?

Dr Morrison: I view the range of services that people can access as a wheel with spokes. The thing that you need is in the middle, and the problem is the point of entry. Over my career, I have seen four or five attempts to properly integrate the relevant services. The health and social care integration policy at least took the proper step of legislating and restructuring services. However, we are not quite there yet in terms of proper signposting.

In the case of your constituent—whose problems you say would be solved by having her toenails done and her bunions sorted—if she is accessing the system from the wrong point of

entry, because people do not necessarily know where to access the system, does someone point her in the right direction rather than just saying that they do not do whatever it is that she needs done? We have to get better at that.

People have talked about the idea of a care navigator. The problem is that people tend to think of that as requiring investment in a new member of the multidisciplinary team rather than as something that requires development of systems that allow individuals, families and carers to do the navigation for themselves.

The issue comes back to what colleagues have said about time. If the penny drops with a member of the wider health and social care delivery team that what Alex Cole-Hamilton's constituent needs is a chiropodist, that person must still have the time to be able to sort things out by pointing the person in the right direction. We still have complexity in health and social care systems, which makes that difficult.

Jonathan Burton: Community pharmacy services and pharmacists in GP practices see themselves as having a care-navigation role. At the moment, that role is minimised because we are not fully plugged into the system. We discussed that at the previous primary care hearing. We would have a lot more to offer patients, and could do more to ensure that care transitions are more seamless, if we were able more easily to share our findings with our colleagues.

I want to address the culture issue, because it is important. Some of the best conversations that I have in the pharmacy start when a patient approaches me and says, "I'm not really sure whether I want this medication. Can I have a chat with you about it?" If that is the opener, I know that I am going to have a great conversation, because that has opened the door for me to say, "Right, put your cards on the table. Tell me what you chatted about with your GP, if you don't mind, and let's discuss the pros and cons."

That is important because, at the end of the day—I am always saying this to patients—when we give them medication, it is up to them what happens next. It is their choice whether to take it or not. We do not mandate or force them to do anything. Therefore, they need to have the confidence and the assurance that the medicine is the right option for them. At some point in the process, they might figure out that it is not the right option for them. In that case, it is okay to come back to the prescriber or me and say that they are not, on balance, comfortable with the medicine. When someone does that, we can have a conversation about how we can support them and whether there are other things in their life that can help them through their particular illness.

On the culture side of things, there are messages that we need to be putting over to patients and the public, but there are also messages that we need to take on board as health professionals. I was taught to tell a person about their medicines, but I was not taught to have a conversation with them about whether they are okay with taking those medicines. There is a critical difference between those things. We need to move in the direction of the latter, but it will take time and a certain amount of trust, which we can build only if we have adequate consultation time.

Emma Harper: I have some questions about prescribing powers for allied health professionals and non-medical prescribing. The 2009 strategy "A safe prescription: Developing nurse, midwife and allied health profession (NMAHP) prescribing in NHSScotland" contained the aim to increase prescribing by nurses, midwives and allied health professionals, including optometrists. Last Friday, I spoke to an optometrist in Stranraer; Elaine Hawthorn is an independent prescriber and is very appreciative of the fact that she can now prescribe medicines. How far have we come since the 2009 strategy in respect of ensuring that there are more non-medical prescribers?

Eileen McKenna: That is a good question. The 2009 strategy has not been reviewed and updated. The changes to access to non-medical prescribing by nurses, midwives and allied health professionals has been a long journey, but it has been a progressive one. The latest figures that we have looked at are figures on the growth in independent prescribing by nurses and the V300 prescribing qualification. In the past five or six years the number has grown in Scotland from 3,000 to nearly 5,000 nurses. Growth has been slow, but there has been a culture change.

With the Nursing and Midwifery Council's new standards for undergraduate nursing and midwifery education, the rules are changing and the view is that nurses will be prescribing-ready at the point of their registration. Until 2019, nurses had to be three years past their registration before they could undertake a non-medical prescribing course. That is changing to one year—they will be able to do that as long as they can demonstrate the competencies.

I think that there will be further growth in non-medical prescribers, which will bring benefits. The evidence so far has highlighted the benefits for the system and for patients of non-medics being able to prescribe.

Emma Harper: I am sure that you agree that having more people who can prescribe, review and reconcile medicines will support better community engagement. What do you think about widening access even more to include, for example, specialty paramedics?

Jonathan Burton: I can add some detail on that, if it would help the committee. When I did my homework last night, I checked the current list of prescribing professions. Non-medical prescribing has its roots in something called supplementary prescribing, in which some of us did our initial qualification 15 or 20 years ago. That allowed non-medical and dental professionals to prescribe according to a management plan that was agreed with a medical prescriber. That is how wider prescribing rights were initially rolled out.

Eventually, independent prescribing rights were introduced, whereby non-medical and dental professionals were able to be more autonomous in prescribing, which suited many of the more acute situations.

At the moment, the list of professionals—it covers Scotland, too—includes various pharmacists, who prescribe in different settings; nurses, who prescribe across a range of settings and at different levels; chiropodists; dieticians; podiatrists; physiotherapists; therapeutic radiographers; optometrists; and paramedics. Some of those professionals prescribe in very specialist areas, and the prescribing rights are being developed to support them in their practices in order that they can provide the best care to the patient who is in front of them.

11:45

The change has brought opportunities, but it has also brought challenges. While we are meeting here, the Royal Pharmaceutical Society is hosting a meeting in Glasgow to launch our designated prescribing practitioner professional guidelines and framework document—"A Competency Framework for Designated Prescribing Practitioners". Until now, in most circumstances non-medical prescribers were required to do additional training under the direct supervision of a DMP—designated medical practitioner—who would be the doctor or medic supervising the process. That has been broadened to include other non-medical professions.

However, we need to be mindful that prescribing is not just about getting our hands on a pad. As we have already discussed, there are aspects to prescribing other than prescribing the medicine. How was the diagnosis reached? How was the decision about the medicine being appropriate reached? What if we want to stop prescribing a medication? What if the best option is to do nothing, or to prescribe nothing and recommend a non-pharmacological intervention?

I do not have the figures in front of me, but pharmacist prescribing, like nurse prescribing, has gathered pace, and we have had to think about how we equip ourselves for those new roles. A prescribing qualification is one thing, but those of us who work in acute settings and deal with common conditions have had to work with NHS Education for Scotland and the medical schools to create a clinical skills pathway, to ensure that we are diagnostically capable of dealing with conditions that we have not been used to dealing with over the counter in the pharmacy, such as ear infections, tonsillitis and higher-level dermatology conditions.

There are great opportunities, which is fantastic for patients, but we need to be mindful of the need to build into every part of the process quality and checks and balances.

Emma Harper: Obviously, further measures relating to education, competence, assessment and development have to be implemented, especially if we make changes to enable pharmacists to look at branded and generic drugs as well as biosimilars, which were mentioned a lot in our previous couple of evidence sessions. Do changes need to be made to enable pharmacists to develop skills on biosimilars and branded meds?

Jonathan Burton: That is happening already. I will use biosimilars as an example. We have pharmacists who are doing fantastic work on moving patients who are on originator-branded products on to biosimilars. Their work is great not just because they are able to switch people on to cheaper and more cost-effective products for the health service, but because they can help to manage that process.

If you were a patient, you would be worried if someone said that they wanted to tweak a fantastic product that had changed your life. Pharmacists are equipped to manage the process and to ensure that the patient is provided with proper support on their journey, rather than it just being a quick switch. We have a lot of the capability—I am sure that specialist nurse colleagues have a lot, too—to manage the process in an effective and caring way, with pharmacists being mindful of the need to keep the patient at the centre of that process.

We have spoken about medicine waste. When does that happen? We get medicine waste when the patient does not know what is going on and does not buy into or see the value of the medicine. The patient might be too embarrassed or afraid to come back and ask for what they received previously. We are doing good work in that area. We have in place some of the right training processes, and a lot of specialists are involved in that. It is just a case of making sure that the work is done properly.

Miles Briggs: What we have just heard leads on nicely to my questions, which are on repeat

prescribing. Jonathan Burton spoke about de-prescribing. In your experience, what proportion of repeat prescribing is avoidable?

Jonathan Burton: It is really tough to put a percentage on that, so I will not do it. However, I will say that, given the appropriate resource, support and time, we can do better in supporting people with their medicines and ensuring that repeat-prescription systems are not churning out scripts that are not needed. We all know that there are medicines in the system that are inappropriate, not necessary and just not right for the patient, so we need to do more work on that. I hope that we can, with the right evolution of the community pharmacy contract, work on our brief interventions, and have a spotter role through which we pick up when things are not quite right for patients whom we know well—for example, through unusual ordering patterns.

It is about having a conversation and asking the patient how they are doing with their medicines. If people trust us and know us well, and we are embedded in their communities, we will start to get some good answers and stuff that we can work with. I would hope that I could, with some cases, pass the baton to pharmacist colleagues in general practices, and say that the patient needs a polypharmacy review, or that something is not quite right, and ask general practice colleagues to take on the case and see what can be done.

That is the way that I see things heading. It is difficult to give a percentage, but there is good work that needs to be done on that.

Miles Briggs: On finding solutions, is it fair to say that IT and data are the key problem in respect of enabling all professionals to add value and to assess whether something is needed?

Jonathan Burton: As was mentioned by the previous panel, we lack data on what happens when drugs get to patients. Community pharmacy could add a lot of value if we were plugged into the system and able to feed back in a timely manner, with different strata of urgency, when we spot problems. That data would be really useful. We would hope that the data set would be completed when the patient attends for a GP or specialist nurse review, or for a GP pharmacist review. We would then start to rake in data on that. It comes back to the old chestnut that, because we are not all plugged in together properly, we lose data and we are haemorrhaging outcomes.

Dr Morrison: Hindsight is a fantastic thing. I would break down the issue of repeat prescriptions into two types. There are cases where prescriptions have been rumbling on for a while and where opportunities have been missed to review the situation, and perhaps for the patient not to be on something anymore. That is one group, and it is probably more community-care and primary-care based.

I work more on a case-finding basis. For example, it often happens that, as a result of a new clinical problem that occurs acutely, somebody who has been fit and well at 83 is no longer fit and well at 83. To be slightly facetious, I sometimes stand on my ward round looking at a repeat prescription list and thinking, “What on earth are they on that for?” What I really mean is that that is the opportunity to review many of those medications.

The point about data is well made, because sometimes the reason why a person is on two or three medicines is totally lost in the mists of time. We get a huge amount of data in referrals from primary care, and that is on our electronic systems. With a huge amount of data, the issue is finding the needle in the haystack that tells us why a drug was once prescribed in 19-oatcake. Sometimes, you just have to make the decision to change the medication because of the risk to cognition and the risk of falls and actual harm to the patient.

I would break it down into those two issues. Clearly, opportunities are missed to reduce medication use when people are absolutely fine and are rumbling along on their prescriptions.

In secondary care, there is also more that we can do to put systems in place—first, to ensure that medication reviews happen; secondly, so that they are reasoned; thirdly, so that they are communicated properly; and fourthly, so that the data allows primary care to understand why that idiot Morrison has stopped all that lady’s drugs. We have to get better at that.

We have talked a lot about IT. As an illustration of where we are with IT in some places, on my ward round yesterday, it took me 15 minutes to get a laptop that would work. I view electronic prescribing as a panacea for some issues, but I wonder how much longer it will take me to do my ward round when we introduce it, because I can currently change a person’s drug chart in five seconds. I bet that it will take three or four minutes to do it electronically. Time and investment in the systems to do that are critical.

We are missing lots of opportunities not just to reduce wastage but to reduce harm. Let us go right back to what we are trying to do, which is to make sure that patient outcomes are good. We have a long way to go.

Miles Briggs: You make some good points. There is frustration because, as I said last week, we have been talking about the issue for 20 years and we do not seem to be any further forward.

What impact has the judgment in the Montgomery v Lanarkshire Health Board case concerning meds reviews had on the professions that you represent? Has it changed informed consent and how people look at what patients are prescribed?

Dr Morrison: I think that it has probably had less of an impact on prescribing than on the very physical things that, for example, surgeons do to people. There are circumstances in which, unfortunately, it has pushed decision making—not always appropriately—much more in the direction of patients. It could be said that we are trying to do decision making in a patient-centred and patient-informed way, but in the face of the Montgomery case, there is a risk that we give the patient a list of the 500 things that could go wrong and say, "After you have read that list, if you still want me to do this to you, let's talk." It has changed the dynamic in good ways but also in less positive ways.

From a personal perspective, I work in a permanent pessimism mode, which involves recognising that almost everything that I do has the potential to harm as well as benefit someone. That is the juggling act that I perform all the time when I am doing or not doing things. To some extent, the iteration of that means that we have to think out loud with the patient and/or their carers and family, "We could do this but it might do that," or "We could do that or not do that." I might not be the best person to speak about the issue, because I am not sure that Montgomery made a big difference to me. I have been practising in the juggling all the risks environment for a long time now, but I feel sorry for people who do very physical treatments who, within the time available, have to explain all the things that could go wrong. That is the ultimate consequence of Montgomery; it is about the balance of explaining risk and benefit. It has had unfortunate unintended consequences.

Jonathan Burton: The Montgomery case has had more of a general effect, and it is something that might have been developing anyway. I will give two examples of that from a pharmacy perspective.

We are becoming a lot more comfortable with discussing the downsides of treatment with patients. One stand-out example is the Scottish patient safety work on non-steroidal anti-inflammatories, such as ibuprofen and aspirin. Going back 10 years, would I have had a conversation with pretty much every patient who was buying or being prescribed ibuprofen in my pharmacy about what could go wrong? Probably not. Do I do so nowadays? Almost every time. It is standard practice. It has permeated through what we do. Almost everybody who purchases or is prescribed a non-steroidal anti-inflammatory should get the conversation. It might be the umpteenth time that they have had the conversation, but they will be reminded about the stomach-related risks, what to do if they get dehydrated and the fact that, if they get side effects, they should not carry on but should raise concerns.

12:00

The second example is not an NHS issue, but it is a medical issue for those of us who run private services for vaccinations. Over the past few years, there have been a few critical incidents involving the yellow fever vaccination, which carries a very small risk of very serious side effects. It is a live vaccine, so it should not be administered to patients who are in any way immunosuppressed or who, for example, do not have a thymus gland; there are various medical contra-indications. Some of those patients have slipped through the net, and there have been some really awful incidents.

Therefore, every time I prescribe and administer a yellow fever vaccine, I have to have a brutally honest conversation with the patient, especially if they are over the age of 60; the risk goes up at age 70 as well. We are still talking about a risk of single to double digits in the millions, but the side effects are really serious, so I have to have an up-front conversation with the person about that. We now more routinely deal with medical exemption certificate scenarios for some of our older patients, rather than automatically defaulting to vaccination. Those are tough decisions, and they have to be co-produced. That approach involves more difficult conversations, but it is becoming a more accepted part of our practice. The effect of the judgment that Miles Briggs mentioned has permeated down.

Eileen McKenna: I echo what my colleagues have said. Nurses have always practised within their code of conduct, which states that we must get informed consent for any intervention. I would hope that people are not becoming more risk averse—there is a risk with everything, but sometimes the benefits outweigh the risk. There is a need to make a professional judgment and have conversations with individuals.

Emma Harper: I have a supplementary that might be best directed at Lewis Morrison. HEPMA has been in place in NHS Dumfries and Galloway for a number of years, and safety in prescribing is a big issue. I am interested to hear your thoughts on electronic prescribing. You said, for example, that it takes four minutes to prescribe electronically and just a few seconds to prescribe by hand. However, I am aware of errors with insulin prescribing that occurred when the letter "u" in a written prescription was interpreted as a zero, so

the patient got 100 units of fast-acting insulin instead of 10 units.

How do we reconcile speed with safety? As part of HEPMA, are we tracking the time that it takes to prescribe? Safety should be paramount—I say that as a type 1 diabetic—and there is obviously a concern in that regard.

Dr Morrison: That highlights the complexity of the area and the relationship in the clinical environment between the time that is takes to do things and the safety of the things that are done. It is complicated. Most of us in secondary care look with some envy at those in primary care, because of how far ahead they are with such systems.

You are right to highlight that writing prescriptions on paper carries additional risks. In my clinical team, we have discussed what we would need in order to move to an efficient and safe electronic prescribing environment. The kit that we currently have does not provide for that, which explains the slightly luddite statements from me and my colleagues about a potential move to electronic prescribing. Knowing what we have in place at the moment, we would ask how that would be done.

Electronic prescribing is definitely potentially safer. However, the experience of certain systems in primary care tells us that if a warning flashes up every time someone tries to do anything, they become habituated to it. They would need to differentiate between the warnings for things that might happen one in a million times and those that relate to a real and definite high-percentage risk. If someone gets flashing red warnings all the time while they are trying desperately to do a repeat prescription for 10 medications, the impact of those warnings will wear off. With regard to the ease of use of systems, the answer is somewhere in the middle of all that.

To come back to prescribing at ward level—as secondary care is the environment that I know—wheeling around large laptops that take 10 minutes to boot up is not the answer. Having something in your hand that is the size of a small iPad, or some electronic stuff at the patient's bedside, would work. Such systems exist in some places in the UK—they certainly exist in Europe, and they definitely exist in the States—but when I look at what we have in many places in which clinicians work in Scotland and the journey that we will have to go on to get there, I know that that will take a lot of investment.

You are absolutely right—ultimately, we have to do what is safe. However, if an electronic system is introduced as being safe but we do not have the equipment to deliver it, it is just as unsafe as a paper system.

Brian Whittle: I was struck by the point that is made in some of the written submissions about how appraisals that are conducted by the SMC are being undermined. In its submission, the RCGP stated:

"there is a clash between what is the most cost-effective medicine"—

and the medication with the best outcomes—

"and patient preference."

In some cases, the internet has a lot to answer for.

The RCGP went on to say:

"On such occasions, GPs, health and social care partnerships and NHS boards will receive letters from patients and politicians"—

some are from politicians, apparently; I do not know who they could be—

"asking for drugs not deemed to be cost effective."

Obviously, the patients have formed their own opinions.

The submission then states:

"This undermines the appraisal system that we have and means some patients are being maintained on drugs"

that are perhaps not the most cost-effective or the most effective for their condition.

With that in mind, what can be done to support prescribers in upholding advice on the most cost-effective and clinically effective prescribing?

Jonathan Burton: I can make a general comment about that. We in pharmacy—and anybody who works in healthcare—will, at some point, have to deal with a complaint or grievance from a patient who feels that they have not been treated properly.

For a number of years, I was a superintendent pharmacist in addition to my patient-facing role, and I dealt with our safety systems if we had any grievances from patients and/or their families. Whenever an error occurred—it is a fact that errors occur in healthcare; we have to admit that and work to improve things—and the situation was handled sensitively and honestly, a complaint rarely escalated to me; it was usually dealt with by the clinician or pharmacist on the ground. When people, their families and their representatives feel that they have not been treated properly, the communication was not right and their views were not taken on board, things usually get tricky.

Some situations might be unavoidable—they might just be really damn tricky. However, there is a lesson for all health professions to learn if patients are having to engage with their MSP and write letters. What has happened before that? Who has spoken to the patient about the treatment? Have there been honest conversations

before it got to that stage? Does the patient—and the clinician—appreciate both sides of the argument, or has there been a diktat? Have they been refused something without explanation?

My guess is that a lot of complaints are to do with communication issues. That does not take away the problem, if the patient still feels that they are being denied a treatment that they consider to be suitable for them. However, as I develop through my career as a pharmacist, if I have had a negative experience or have not managed to meet a patient in middle, I always try to think about what I could have done better, whether I explained things well enough and whether I showed empathy. There is a person-to-person element to this.

That does not answer your question about the political level stuff, but we should always aim to reach agreement and resolve issues at the patient-to-practitioner level. Work is still to be done in that regard, and we always need to be mindful of how we treat people.

Brian Whittle: That brings us back to the issue of culture. When it comes to improving things, it strikes me that there is a tension between the culture in the general population and the culture in the NHS with regard to what happens when mistakes are made, which is an inevitability. I am digressing slightly, but I come back to the need for a shift in culture, which is probably one of the hardest things to achieve.

The Convener: I am keen that we do not digress too much, given the time. If people have thoughts on that, perhaps they could be wrapped up with an answer to a different question.

Emma Harper: The witnesses probably heard me asking the previous panel about over-the-counter meds; I asked about the issue last week, too. We continue to hear people ask, "Why can't folk just buy their paracetamol for 12p from the supermarket rather than have it prescribed?". I am aware that paracetamol is an adjunct to other pain meds—it can be taken to reduce the number of opiates that somebody is taking, for example. I know that NHS England has adopted a policy that limits prescriptions for over-the-counter meds for an array of different conditions, although patients might still be prescribed those meds in some circumstances.

I am concerned that if we start saying to folk, "Sorry—you can't have your paracetamol on prescription; you need to go and buy it," that might be an issue; it could mean that people would not take the meds. What are your thoughts on whether Scotland should pursue a similar policy to the one that has been adopted by NHS England?

Dr Morrison: It is not worth the grief. To be really reductionist about this, by the time that somebody has accessed healthcare in order to seek a prescription, there have already been associated costs. You are highly likely to engender some fairly major friction in the relationship between the healthcare professional and the patient by getting into that discussion. That is what it boils down to—the prospect of individual clinicians getting into a position of difficulty with the people they are treating.

If we take a whole-system approach, I believe that we have not properly analysed the cost of what happens if we do not have free prescriptions, because measuring the cost of healthcare time is not that easy to do. To come back to what I said at the start, if we were to move to a system where, by the time that people have accessed healthcare, they are expecting the clinician to prescribe them the medicine and instead we send them away to buy it at the supermarket, I genuinely do not think that it would be worth the cost to the relationship of patients with their clinicians and the healthcare system. We need to think about the value of that relationship.

By all means, if there is a good economic analysis of why we must adopt such a policy, which includes the opportunity cost of the healthcare time that is lost having an argument about the issue, somebody can come back and try to convince me, but at the moment I am absolutely unconvinced that we should go down that route.

Jonathan Burton: I very much agree with that. Basically, there are three classes of medicines: general sales medicines, which you can buy pretty much anywhere, including in the supermarket; pharmacy-only medicines, which can be bought only from a pharmacy; and prescription-only medicines.

Deciding what we are and are not allowed to prescribe as practitioners in the NHS based on the legal classification of a medicine is, to my mind, quite ridiculous. I will give you the most ridiculous example, which always slightly annoys me. It is the example of emollient products for the treatment of eczema and other chronic inflammatory skin conditions. As somebody who sees patients with dermatological conditions in the walk-in clinic in my pharmacy—I am a non-medical prescriber—that is one of the mainstays of the treatment plans that I put together for patients. The fact that that product happens not to be a prescription product does not diminish its value or the importance of having adequate support and adequate supplies of that medicine for the patient, because they are probably going to need quite a lot of it. Do not even get me started on the paracetamol argument.

However, there is an argument—to go back to the earlier self-care discussion—that we all have a responsibility to coach and instruct people on the

acceptable rules of the road in terms of self-care. I would always advise patients to keep paracetamol, ibuprofen and some indigestion remedies in their home medicines cabinet, so that they can manage minor symptoms themselves. That kind of thing should be managed through self-care in a home environment, with additional advice from us, if needed. However, when people present because they are acutely unwell and need advice, it is our responsibility to make sure that they get that advice, and sometimes the medication that they need. The legal classification of that medicine should not really come into it.

You can always ask people what they have at home, though. If I see somebody with a sore throat and I decide that it is viral, we will have a chat about the symptoms and I will give a bit of a worsening statement and some self-care advice. The first question that I will ask is, "What do you have in your medicines cabinet?" I will not whip out a prescription pad straight away. That is just common sense.

12:15

Eileen McKenna: Culturally, the message about the paracetamol argument is getting out to the public, but a blanket approach to other medicines should be taken only with caution, because any blanket approach always has unintended consequences. We know that we have health inequalities in Scotland. If we were to say, "These medicines can't be prescribed," would one unintended consequence be the widening of those health inequalities?

David Torrance: The Scottish Government's vision for primary care, which recognises the benefits that the wider healthcare team can bring, includes a greater role for pharmacists. However, that has had the unintended consequence of increasing workforce shortages in community pharmacy, and there have been calls for the role of pharmacy technicians to be expanded to help alleviate that pressure.

Are pharmacists bringing the anticipated benefits to general practice? Is the current skill mix and workforce adequate to enable them to perform that extended role?

Jonathan Burton: In looking specifically at the role of pharmacists in GP practices, it is important to state that pharmacists have worked in primary care in a non-community-pharmacy setting—in GP practices and health boards—for many years. I spent six months working in a GP practice 19 years ago, and it was not new even then. What has changed is that, in the past couple of years, there has been a move to develop a role that primarily involved prescribing, advice and support into a role that is much more tightly integrated into the workings of the GP practice and which has—or should have—a strong patient-facing element.

We have an NES-supported training programme to make sure that pharmacists who work in that environment are well supported and briefed in their role. In addition, the recent changes to the GP contract included a new pharmacotherapy component that is very prescriptive about what pharmacists and pharmacy technicians should be doing. The basic building blocks are there.

The Royal Pharmaceutical Society has heard some concerns from our professional colleagues about the new role of pharmacists. We do not want to end up in a position in which pharmacists are effectively propping up practices by administrating prescriptions and doing clerical work; they want to use, and make the most of, their patient-facing skills. In many cases, pharmacists have been parachuted into struggling practices and have done a fantastic job of keeping the show on the road. However, overall, they want more guarantees to ensure their autonomous practice and the use of their clinical skills to the best of their ability.

We are starting to see some unintended consequences of the influx of pharmacists into GP practices, although that has not quite filtered through in the workforce reports that we get from NES and Community Pharmacy Scotland because the situation is developing so quickly. We are talking about a trend that has exploded in the past 18 months or couple of years.

We need to be mindful of the fact that pharmacists are a finite resource. There are only so many of us in Scotland, and our skills are in great demand not only in GP practices but on hospital wards, in admissions and discharge processes and in community pharmacy practice through our patient-facing roles. If you want pharmacists to do more in our communities, that takes more resource, and more of us.

The Royal Pharmaceutical Society recently did a piece of work on workforce pressures and mental health in the pharmacist workforce.

We are currently collating the data from a big survey that the RPS completed towards the end of last year. The initial results do not make pretty reading in terms of the stresses and strains on pharmacists that arise from workforce issues and additional clinical responsibilities. In many ways, we are up for the challenges, but—like any other health profession—we need to be mindful that we need the appropriate support, and the time and space, to enable us to do our jobs properly.

It has been announced that an additional 20—I think—postgraduate training places will be introduced in the near future. However, we know that there are challenges at our two Scottish

schools of pharmacy around recruiting appropriate numbers and appropriate people for our master of pharmacy courses. Again, the Royal Pharmaceutical Society is asking for attention to be paid to promoting the jobs of pharmacist and pharmacy technician as a good career choice. We do not have the benefit of years of people watching actors on "Casualty" and "Holby City" running down corridors with white coats flapping in the breeze; we are seen as a behind-the-scenes profession. Although the public perception is changing, we need to work on that so that we can attract good people to our undergraduate programmes.

There are definite challenges before us, and any further development of the GP contract needs to be mindful of the fact that pharmacists are needed in community pharmacies and in secondary care. They are already doing good work, and they need to be supported further in that.

Miles Briggs: You have half answered my question, which concerns the destabilisation of the pharmacy workforce. Concerns have been expressed to me about the huge movement of pharmacists from community pharmacy into GP surgeries and acute care. What do you think of the Government's workforce plan in that regard? I hear what you say about the 20 extra training places, but concerns have already been expressed around the unavailability of staff to cover locum shifts in community pharmacy and so on.

Jonathan Burton: It is fair to say that we currently have an increasing amount of workforce data because of the workforce surveys that we have started to do in the past few years. However, as I alluded to earlier, the rapid nature of the change that has been happening has caught a lot of us off guard. The sheer number of pharmacists who are required to be in GP practices to support the pharmacotherapy component of the GP contract has started to have an impact on other healthcare settings.

Do we need better workforce planning? Do we need to examine the work that we do with schools so that our degree programmes are full and the right sort of candidates come forward? Absolutely. We need to keep shining a light on that issue, because we need to have good people in the pipeline. We need not only pharmacists, but a pharmacy technician workforce to support us in what we do. That involves technicians working in GP practices; in the hospital environment, where they do great things; and in supporting people like me so that we can deliver more clinical services without having to split ourselves into eight bits every working day.

Sandra White: I have championed community pharmacies because they do a fantastic job, so I have listened with interest to what you have said, Mr Burton. You paint quite a frightening picture.

People know the staff who work in their community pharmacy. Every time that I visit the community pharmacies in my constituency, people tell me that they support pharmacists' ability to prescribe medicines and that they are in favour of pharmacists having a greater role in doctors' surgeries, hospitals and the community. However, you are suggesting that, because of the changes, you will not be able to deliver that community pharmacy service, and that there are problems with technicians in that regard. Is that correct? Do you have a timescale for that?

Jonathan Burton: We are like any other profession: we have a certain capacity, and when it is reached that will naturally have an impact on what we can deliver in our patient-facing roles.

With regard to opportunities, it is an interesting time for our profession. What we are being empowered to do via non-medical prescribing and the evolution of the community pharmacy contract is fantastic. We are in a really good place, and we are the envy of those in other countries in the UK. There is no getting away from the workforce issues, but we can manage them.

The responsibility for encouraging people into community pharmacy roles lies in many different places. For example, it falls on people such as me, who represent the profession, to ensure that young people and colleagues know how wonderful it is to work in a community pharmacy and that they are aware of the potential in the job and the joy that it can bring. There is also a responsibility on Government to examine the numbers, and on everybody at management level in community pharmacy and in the NHS to reach an agreement so that we can get a bit of stability in our workforce.

In general, we get on quite well in pharmacy in Scotland, and we know what the issues are, so we have the capability to keep things on track. However, there is no getting away from the fact that there are issues. We need to be honest about what the problem is, as that is the first stage in sorting things out.

Sandra White: I will move on to my next question, which is on something that might create more pressure.

In last week's meeting, I raised the issue of care homes, and we heard from pharmacists that they are very keen to be able to work and prescribe in that setting. The submission from the Royal Pharmaceutical Society makes some suggestions in that regard, which include more pharmacy input and bulk buying.

My question is not necessarily about that particular point, although it may possibly be related. In the current circumstances, are care home residents receiving the best pharmaceutical care? Why is the waste of medicines—a key issue, as we have heard today and in previous weeks—at such a high level in care homes, and what can be done about it? The question is for everyone on the panel, if they wish to answer.

The Convener: Who would like to start?

Dr Morrison: In general, care homes are full of pretty frail elderly people. I hope that I can speak a little from a position of authority about that sector. The answer is never unidisciplinary. The principle that those who are in institutional care should get the right care, and the right access to care, in a way that is not fundamentally different from the experience of the rest of the population—there is a risk of ghettoising those in care homes—cannot be fixed by pharmacists, doctors or nurses alone.

We should consider the evidence for what works for care in that setting, and we have to acknowledge that the population is different. People in care homes are not the average elderly population; they have very particular needs. The evidence shows that what works is a proper well-resourced multidisciplinary team that has the time to deliver effective care home medicine. We can track the outcomes using one simple measurement, if nothing else: the number of out-of-hours admissions of care home residents through A and E to medical admissions units. A functional care home team can make a major impact on those figures.

It is outwith the remit of what we are talking about today, but I note that prescribing can also be used as a proxy measure. Are we taking a proper, multidisciplinary approach to prescribing for the care home population? That is to do with rationalisation and having proper conversations, which reduces wastage.

In the context of care homes, an approach that says that we simply need more people in X, Y or Z does not work. The evidence base, on which I would focus, says that there must be a multidisciplinary approach.

Eileen McKenna: I agree with that view. The committee has previously had written submissions from the Royal College of Nursing Scotland on the role of registered nurses in care homes and our concerns about the lack of nurses in that setting. We have an opportunity to change the current situation through the transforming nursing roles programme, which is focusing on that area. It is looking at promoting and developing specialist and advanced nursing roles in care homes to carry out assessment, diagnosis and onward referrals, if required, and potentially to undertake prescribing duties and improve medicines management and outcomes.

12:30

Jonathan Burton: In the past few years, the Royal Pharmaceutical Society has done a couple of reports on pharmaceutical care input in the care home environment. I echo what my colleagues on the panel have said about improvement being a team game. We have recently called for some recognition of the specialty of pharmacist input into the care home environment, and for the opportunity and resource to allow pharmacists to engage with care homes and become another member of the team more permanently.

Currently, most supplies of medicines to care homes are administered through the community pharmacy contract. The care arrangements regarding the review of patients are much more of a mixed picture. Health board-employed pharmacists will sometimes be attached to care homes, but they usually just go into a care home, try to deal with any issues there and then move on to the next one. In that way, they assist and provide services in quite a lot of care homes. We would like to see a much more stable situation in which a pharmacist becomes, in effect, a member of a multidisciplinary team and a known face in that environment. In that way, we can make a bigger impact on patient care in a particular home, which will involve undertaking a polypharmacy review.

There is also a big training angle with regard to training care assistants and people who administer medicines on the safe and secure handling of medication, because there are a lot of technical pharmaceutical aspects to deal with in care homes. In that sense, our report was multifactorial.

Sandra White: I am the convener of the cross-party group on older people, age and ageing, which has heard a lot about care homes. I am worried that elderly people in care homes are simply being given tablets without any conversation about that, and with no other options presented. In the short term, do we need multidisciplinary teams in care homes that are able to have conversations with patients and perhaps offer something else? At present, unfortunately, it seems that patients are just being given tablets, and as we know, wastage in care homes is greater than it is in other areas.

You do not need to answer my question if you do not want to; I just wanted to get the point out there.

The Convener: If the question is whether we all agree that a multidisciplinary team approach is required, I suspect that the witnesses might have answered it already.

Eileen McKenna: My answer to the question is yes, but we need to make a distinction between care homes with nursing care and those without. Input from registered nurses in care homes must be valued, and we must recognise that the population in care homes has shifted significantly, which means that a multidisciplinary team approach is absolutely required. However, the team should be based in the care home, rather than going in and out to provide episodic care.

George Adam: Good afternoon, panel. Much of the evidence that we have received so far shows that there is a desire to move to value-based pricing for drugs. I know that the matter is a reserved issue and is currently before the UK Government. Do you support the idea of moving to value-based pricing?

The Convener: That means pricing based on the value of the benefit, rather than purely on cost.

George Adam: I assumed that the panel would know that.

Jonathan Burton: If you are asking whether our current processes and institutions are robust in that regard, I would say, as a practitioner, that they are generally robust and that we get good value for money with our medicines in the UK. It is quite a big question, but if you are looking for a general comment, I would say that we always need to look at the value of products, not just the cost.

George Adam: There is obviously an issue if the UK Government is considering a change so that drug prices are based on the benefit that a drug brings to the individual who is using it, and it is a topic for on-going debate in the Scottish Parliament and the healthcare industry. Do you see it as a way forward or not?

Jonathan Burton: I am not sure that we are far enough along in the debate for me to comment.

Dr Morrison: I will be honest: I am not sure that I understand the question. It depends what you mean by value. We have talked a lot this morning about the human aspects of medication usage—there is a lot of value in there. At the end of the day, when we procure medication, we have to be able to say that it works. There is then a subsidiary question about who is making the decision about whether it works. It is a hugely complex landscape.

Apart from a year working in Gateshead before I was sent back to Scotland, I have spent my entire career here. I am confident that the current mechanisms are better—absolutely better—than those that were in place at the start of my career. The landscape was very different in the 1990s, particularly in relation to the starting point: where we get the medicines from, whether they work, what the evidence base is, whether they are safe and how we monitor that.

The current situation is vastly better than it was. On the day that I qualified, the attitude was pretty much, "There's your 'British National Formulary'—off you go"; it should be borne in mind that the BNF is the most dangerous book in the world. The systems are so much better than they used to be. We need to be really careful not to deconstruct some of the major advances that we have made in the way that we procure, prescribe, use and prove what we are doing with medication—we have to bear in mind how far we have come.

George Adam: I am trying to get at the point that Lewis Morrison mentioned earlier. If you are looking to get someone with a long-term condition on to a different medication that saves money and has been proven to help the patient, how do you have that conversation? It goes back to what you said earlier about moving a patient on to a new drug. How do you get to the stage where you are talking about how it is good for the individual as opposed to them or their family members thinking that it is simply a cost-cutting exercise?

Dr Morrison: It is about relationships and trust, which is often about time. It would usually take more than one discussion. Nowadays, we tend to view healthcare as something that should all be done right now. Honesty is part of it: I am honest with my patients when I say, "We used to use this drug, but we know that it doesn't work anymore, and there is a point to consider, given what we know, about how much money we are spending on it across a population of people like you."

I can give an illustration of the time that it can take to make changes. I conduct a Parkinson's disease clinic, and I have been looking after some people for five, six, or 10 years. It can sometimes take three appointments to reach a consensus that we are going to make a major change along the lines that you suggest, about a drug that we know no longer works. Of course, there is then likely to be a difficult conversation about why I have been prescribing the drug for them for all those years.

About 50 per cent of medical knowledge changes over a 20-year timeline, as the world moves on. We have to move to a position where the population understands that such consultations are about improving people's wellbeing rather than saving money. That is the point in a nutshell. I am trying to describe in two minutes pretty much what I have been trying to do for my entire clinical life—it is not easy to distil it into a few pithy points.

Medical students who sit in on the clinic with me sometimes say, "How did you do that?" It is an amalgam of knowledge, skills and experience, tailoring the consultation to each individual,

drawing on the evidence base and being able to point people to information so that they can go away and look it up rather than just believing what I tell them. It is an incredibly complex approach, but it is a good one, which is why I use it.

We need to be careful about headlines that say that we are not going to use a particular drug or that another drug has been approved. We need to get better at communication, from the top down. That is probably about as iterative as I can be about that.

Jonathan Burton: I want to put a slightly different spin on putting a value on medicines and how we assess that. We are trying to ensure that when we use a medicine, it delivers maximum value and impact for the patient who takes it. One of the RPS workstreams concerns pharmacogenomics. If you had asked me about it 18 months ago, I could not have verbalised what pharmacogenomics was; it involves looking at how a patient's genetic profile affects the way in which their body handles and maximises the benefit of a particular medication.

A classic example is codeine. From our prescribing data for Scotland, we can see that co-codamol—paracetamol and codeine—is one of the big ones: hundreds of thousands of patients take it and we spend millions of pounds on it every year. However, some of the population—a fairly healthy percentage—cannot metabolise codeine properly: their bodies cannot turn it into morphine, which is what makes it a good pain reliever. If a patient who is a non-codeine-metaboliser takes that medicine, they will probably not get a lot of benefit, but they will get quite a few of the associated side effects—they will not miss out on that fun and will always get the downside.

Looking forward, we may soon be in a situation—perhaps sooner than we anticipate—where we have quick point-of-care testing and the lab ability to check some of the key genetic traits of patients to ensure that we target medicines more appropriately. When we talk about value, it might be less about the actual cost of the medicine and more about whether it is the right medication for that particular patient and whether we can narrow things down a bit more than we could previously.

The Convener: Thank you—that has been another helpful evidence session. As I always say to witnesses on these occasions, if there is anything that occurs to you after you have left the committee that you think that we should have heard, please let us know.

Subordinate Legislation

Foods for Specific Groups (Infant Formula and Follow-on Formula) (Scotland) Regulations 2020 (SSI 2020/6)

Foods for Specific Groups (Medical Foods for Infants) and Addition of Vitamins, Minerals and Other Substances (Scotland) Amendment Regulations 2020 (SSI 2020/7)

The Convener: The final item on the agenda to be taken in public is consideration of two negative instruments; I am sure that we can deal with them promptly.

As members have no comments, do we agree to make no recommendations on the instruments?

Members *indicated agreement.*

12:43

Meeting continued in private until 12:46.

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