THE NATIONAL ASSEMBLY FOR WALES

AUDIT COMMITTEE

Report presented to the National Assembly for Wales on 22 August 2003 in accordance with section 102(1) of the Government of Wales Act 1998

The Procurement of Primary Care Medicines

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Introduction

1. In this report we examine the scope for the Assembly's NHS Department to improve value for money through changing the arrangements by which NHS Wales obtains primary care medicines, taking account of the risks of changing those arrangements. We also examine the potential for savings from improving prescribing behaviour and wider medicines management.

2. On 27 March 2003, on the basis of a report prepared by the Auditor General for Wales[1], we took evidence from Ann Lloyd, Director of NHS Wales, and Carolyn Poulter, Head of the Pharmaceutical Services Branch of the Assembly's NHS Department. This report sets out our findings, conclusions and recommendations drawn from the evidence presented to us.

3. Following the evidence session of 27 March, the Secretary of the Wales Industry Group of the Association of British Pharmaceutical Industry, the Chairman of Community Pharmacy Wales and the Chairman of the General Practitioners Committee (Wales) wrote to the Committee indicating that they would be prepared to give further evidence on this subject[2] and, along with Royal Pharmaceutical Society of Great Britain, they also submitted papers that outlined their concerns on this subject[3]. This is in addition to the comments that the two groups made to the National Audit Office Wales, in the preparation of the Auditor General for Wales' report, and representations made before the evidence session of 27 March 2003.

4. In his report, the Auditor General for Wales made clear that complex systems and arrangements underlie the procurement of primary care medicines in Wales. His report also emphasised that before making any changes to current arrangements, it would be essential to assess fully the costs and risks as well as the potential benefits that any change would bring with it. This was supported and echoed in the evidence that the Committee took. Accordingly, we recommend in this report that the Assembly's NHS Department should obtain advice from the All-Wales Medicines Strategy Group[4] to inform decision-making on proposed changes. We also suggest that the All-Wales Medicine Strategy Group should take account of the views of the Wales Industry Group, the General Practitioner Council (Wales), Community Pharmacy Wales and any other interested parties, and that it would be appropriate for those bodies to present any further views they may

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[1] Auditor General for Wales (AGW) report, *The Procurement of Primary Care Medicines*, presented to the National Assembly for Wales on 20 March 2003

[2] Annex D

[3] Annex B, C, and E

[4] The All-Wales Medicines Strategy Group provides advice to the Minister for Health & Social Services on medicines management and prescribing. Part of the Group's remit is to help reach consensus on medicines management issues.

have to the All-Wales Medicines Strategy Group. This would enable experts in the medicines field to analyse the evidence presented and to take it into account in providing advice to the NHS Department.

The potential savings and risks of changing primary care medicine procurement arrangements

5. The arrangements for procuring primary care medicines are complex, and are shaped by a combination of market forces, government regulation and agreement between government and industry[5]. Over 1,000 individual contractors purchase medicines on behalf of the NHS in return for reimbursement on the basis of the Drug Tariff[6]. Making changes to the existing procurement arrangements brings with it a number of risks and challenges, including a possible reduction in the security of supply[7]. The Director of NHS Wales told us that she considered that the Auditor General's report quite rightly outlined the complexity of the arrangements and the risks attached to changing them, but that she also thought that there was scope for improving procurement arrangements in Wales[8].

6. Part of the complexity of the existing arrangements for the procurement of primary care medicines is the Pharmaceutical Price Regulation Scheme (PPRS). This is an agreement between government, negotiated by the Department of Health on behalf of all UK health departments, and the pharmaceutical industry that indirectly controls the prices of branded medicines by setting limits on the overall profit on pharmaceutical companies' NHS sales.[9] We note that the Assembly does not have powers to change the Pharmaceutical Price Regulation Scheme, but welcome the Director of NHS Wales assurance that the Assembly's NHS Department has a very close and positive working relationship with the Department of Health and would expect NHS Wales to work with the Department of Health to secure appropriate changes to the system.[10]

7. The Auditor General reported that, based on the prices that apply in the secondary care sector, centralised purchasing contracts for medicines in the primary care sector might significantly reduce expenditure on primary care medicines, although achieving savings would not be straightforward and would not be without risk if Wales were to act alone.[11] In particular, his report showed that, if it were possible to match the centrally negotiated secondary care prices for ten

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[5] AGW report paragraphs 2.2 to 2.9
[6] Q4
[7] AGW report paragraph 3
[8] Q4
[9] AGW report paragraph 2.4

[10] Q7
[11] AGW report, paragraphs 3.6 to 3.15

heavily used item in the primary care sector it might yield a cost reduction of almost £23 million[12]. The Assembly's NHS Department Head of Pharmacy Services told us that these differences in prices were the result of discretionary discounting to secondary care on the part of the pharmaceutical industry. She also told us that such discounting is based on the assumption that one hospital prescription will generate some 15 primary care prescriptions, so there is an incentive to encourage secondary care to prescribe a particular company's medicines[13]. Such differential pricing is under pressure from unified budgets, which makes the NHS more aware of the influence of secondary care prescribing on primary care, and from the Napp case in which a company was fined £2 million for loss-leading[14]. Nevertheless, we are concerned that different parts of the NHS are charged different prices. **We recommend that the Assembly's NHS Department monitors the differences in prices charged to the primary and secondary care sectors before making changes to the arrangements for the procurement of selected primary care medicines.**

8. We are encouraged by the Director of NHS Wales' acceptance of the Auditor General's recommendation that centralisation be piloted for a small number of medicines[15], and welcome her determination to take these forward.[16] The Assembly's NHS Department is to ask the All-Wales Medicines Strategy Group to draw up proposals for piloting centralised purchasing contracts for primary care medicines and to advise on the risks involved so as to ensure that an informed decision on commencing such pilots is made[17] in the next six months.[18] **We recommend that the Assembly's NHS Department pursues centralised contracts for primary care medicines on the basis of the proposals and advice that it receives from the All-Wales Medicines Strategy Group.**

9. The Director of NHS Wales told us that NHS Wales would be seeking to develop pilot schemes based both on all-Wales and local health board levels.[19] Each of the options for centralised contracting poses risks and challenges[20]. She told us that local health board arrangement could influence local prescribing behaviour and are unlikely to destabilise national arrangements, and that they may therefore be the best way forward. We are, however, particularly concerned that local health boards, which were only recently established, may lack the necessary experience for complex negotiation with the pharmaceutical industry.[21]

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[12] Q18
[13] Q19
[14] Q20
[15] Q10
[16] Q104
[17] Q10
[18] Q10, 11
[19] Q10
[20] Q10
[21] Q12, 14

10. The Director of NHS Wales acknowledged concerns that the negotiators of centralised contracts, both at the local and all-Wales levels, would have difficulty in negotiating with the pharmaceutical industry and would need expert advice to help them[22]. It should be possible to build on the expertise of the All-Wales Drugs Contracting Committee, who have experience of negotiating with the drug companies and their representatives on secondary care medicine contracts.[23] We note that there is a risk of wasting opportunities through poor negotiation, and that the NHS's approaches will need to be tested.[24]

11. There are further risks associated with introducing centralising procurement contracts, including the possible reduction in the accessibility of pharmacy services, as highlighted in the Auditor General's report.[25] Centralising contracts in the primary care sector will result in reduced levels of reimbursement income for pharmacists. This will affect all pharmacy contractors, but in the case of those at the margins of economic viability, such as those in some rural areas, this may lead to the loss of their services.[26]

12. The reduction of income from reimbursement may also exacerbate GP shortages in rural areas. This is because reimbursement forms part of the remuneration of dispensing GPs, who tend to be located in such areas[27]. We note that, in recognition of the vulnerability arising from making changes that affect dispensing GPs, the NHS Confederation is treating dispensing GPs as a special case in its current review of GP contracts on behalf of the four UK health departments.[28]

13. The Essential Small Pharmacy Scheme provides a potential safety net for community pharmacists by guaranteeing a minimum level of remuneration for pharmacies dispensing low volumes of prescriptions.[29] The Assembly has powers to amend the Essential Small Pharmacy Scheme.[30] **We recommend that the Assembly's NHS Department assess the adequacy of the Essential Small Pharmacy Scheme as a means of addressing the potential destabilising effect of centralisation, and uses its powers to reform the Scheme if it assesses it as inadequate.**

14. The Auditor General's report also recommends that the Assembly's NHS Department considers the repercussions that centralised contracts may have on the pharmaceutical industry.[31] The pharmaceutical industry is concerned that changes to the long established system for procuring medicines could have a destabilising effect and potentially impact on the availability of drugs to

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[22] Q12
[23] Q23
[24] Q23
[25] AGW report, paragraphs 4.7 – 4.10
[26] Qs 16, 30, 33
[27] Q39
[28] Q40
[29] Q37
[30] Q38
[31] AGW report, paragraph 4.12, 4.13

the NHS, industry profitability and research and development. The witnesses were unable to estimate the levels of potential losses that the pharmaceutical industry would bear, but agreed that centralised contracts in Wales alone would most likely have only a limited effect on the overall profit margins and on research and development. However, it was also noted that if changes in Wales were to lead to changes elsewhere, this could have a greater impact..[32] The Director of NHS Wales assured us that the Assembly's NHS Department was under no pressure from the Department of Health to halt the piloting of centralised purchasing contracts because of concerns about the possible wider impacts.

15. **We recommend that the Assembly's NHS Department fully evaluates all its piloting of centralised contracts for primary care medicines, taking account of all costs and benefits, including the effects on access to pharmacy and GP services and the cost of buying in expertise, and that it disseminates the lessons learned before taking such contracts further**.[33]

The potential for savings from improving prescribing behaviour and medicines management

16. There are wider factors outside procurement arrangements that influence NHS Wales' expenditure on medicines[34], and these provide the NHS Directorate with further opportunities for savings. The Auditor General's report highlights how the expenditure on medicines can be significantly reduced by improving prescribing behaviour and medicines management.[35] We recognise that there has already been considerable progress in these areas, particularly with the growth of the development of local formularies and their impact through providing GPs with improved information on prescribing, administering and dispensing medicines[36].

17. However, we are concerned that best practice is not being followed by all GPs and that progress in improving prescribing behaviour and medicines management has not been fully monitored.[37] The Director of NHS Wales informed us that a new performance management system had been piloted and would be operational in all local health boards from 1 April 2003. The system will test advances in medicines management, the control of prescribing costs and the roll-out of new products.[38] We welcome this progress. **We recommend that prescribing behaviour and medicines management advances are monitored by local health boards and the Assembly's**

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32 Q45
[33] Q14
[34] AGW report, paragraph 4.14
[35] Prescribing behaviour is the general trend of the type of prescriptions prescribed by GPs to patients. Medicines management is how best use is made of medicines.
[36] Q24
[37] Q24
[38] Q27

NHS Department using the new performance management framework and that the Assembly's NHS Department keep the Auditor General for Wales updated on progress.

18. The rising rate of generic prescribing is an indication of improving prescribing behaviour in Wales[39]. The rate has risen from 40 per cent to just under 70 per cent over the last ten years.[40] Despite this increase, the current rate in Wales remains lower than England and Scotland.[41] The witnesses told us that the reasons for this, along with the variations in the rate within Wales[42], were not clear. The Head of the Assembly’s NHS Department Pharmacy Services Branch mentioned that the greater prevalence of dispensing GPs in Wales, compared with other parts of the UK, was a possible cause for the lower level of generic prescribing, but that the evidence for this had not yet been examined[43]. However, the All-Wales Medicines Strategy Group is analysing reasons for the variations of levels of generic prescribing in Wales and plans to benchmark with North East England, which has a population with similar characteristics to that of Wales.[44] **We recommend that the Assembly’s NHS Department makes full use of the work of the All-Wales Medicines Strategy Group in setting targets for generic prescribing and developing strategies for increasing the level of generic prescribing where appropriate.**

19. Appendix 4 of the Auditor General’s report lists initiatives currently used to support improvements in prescribing behaviour and medicines management, such as local formularies, prescribing advisers, prescribing incentive schemes and the Welsh Medicines Resource Centre. We note that efforts are being made to evaluate these initiatives, such as the establishment of the All-Wales Prescribing Advisory Group, which will evaluate all local health board prescribing incentive schemes.[45] However, we note that in other cases a more formal approach is needed[46]. We look to the Auditor General for Wales to examine the results of these evaluations when they are completed and update this Committee on the results[47]. **We recommend that the Assembly’s NHS Department draws together the results of its evaluations of initiatives intended to improve prescribing behaviour so that they may readily be disseminated.**

20. We are concerned that some GPs continue to prescribe medicines classified as “of limited clinical value” to their patients.[48] The Director of NHS Wales told us that the cost-effectiveness of

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[39] Generic prescribing is the substation of a branded drug with its generic equivalent.
[40] Q55
[41] Q54. Generic prescribing rates are 74 per cent and 75 per cent for England and Scotland respectively.
[42] 62 per cent to 72 per cent

[43] Q55
[44] Q55
[45] Q69
[46] Q68, 69, 70
[47] Q71
[48] Q65

prescribing such medicines was debatable,[49] as the clinical effectiveness of a drug was often only determined by a GPs clinical judgement, though it should be possible to test whether this judgement were soundly based. Although these medicines were apparently inexpensive, she thought that GPs should still hold a full discussion about what could improve the health of individuals. However, the use of a blacklist, which would prevent the prescription of such medicines from NHS resources, was unlikely to lead to better cost-effectiveness, as previous efforts with such a list a decade ago had led to more expensive items being substituted inappropriately[50]. The Director of NHS Wales told us that justification for the prescribing of such medicines was a matter for the Assembly's NHS Department to take up with GPs[51]. **We recommend that the Director of NHS Wales requests that the All-Wales Medicines Strategy Group reviews the justification for prescribing medicines of limited clinical value and considers what cost-effective alternatives there may be beyond prescription, such as the provision of written dietary advice.**

21. We are deeply concerned that over £15 million of medicines is wasted each year, as identified by "dump campaigns".[52] A major factor contributing to the level of wastage is repeat prescriptions, where patients automatically receive prescriptions without a review of their medical condition or requirements. The Director of NHS Wales recognised that a system must be established where such reviews between the GP and the patient can take place[53] and she assured us that they are currently encouraging GPs to conduct a thorough evaluation of the patient's requirements and the efficacy of the drug before providing a repeat prescription.[54]

22. While we recognise that GP Prescribing Advisers and Pharmacy Technicians currently conduct medication reviews on patients, we are concerned that such reviews are rarely conducted by Community Pharmacists, despite their expertise. We also note that patient behaviour contributes to medicine wastage. In particular, we are concerned that patients are less likely to use generic medicines prescribed to them than their branded equivalent. The Director of NHS Wales acknowledged that Community Pharmacists and GPs could better explain to patients the use of generic medicines as a substitute for their branded equivalents so as to ensure that patients accept them as effective.[55] We therefore welcome the Assembly's NHS Departments plan to draw up a new pharmacy contract, which will remunerate pharmacists for providing professional services, such as medical reviews, on top of remuneration for dispensing prescriptions.[56] We welcome such

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[49] Q67
[50] Q66
[51] Q66
[52] Q73, 85
[53] Q73
[54] Q86, 87
[55] Q73
[56] Q93, 101

efforts as it is evident that the role of community pharmacists in medicines reviews needs to be developed further.[57]

23. Original pack dispensing improves the patient's ability to take the right medicines at the right time[58]. However, differences in pack sizes between manufacturers are a barrier to substitution[59]. We recognise that Wales, as a relatively small market, has limited influence over the pharmaceutical industry to produce a standard pack size, but we welcome the Assembly's NHS Department's establishment of an NHS Industry Forum to address such issues.

Concluding comments

24. Primary care medicines expenditure in Wales has steadily increased over the last ten years, amounting to some £410 million, or 15 per cent of total NHS expenditure. The procurement arrangements for primary care medicines are complex and Wales has limited influence in the overall procurement arrangements in the UK. Nevertheless, the Auditor General's report highlights that the Assembly's NHS Department has scope within existing legislation to alter procurement arrangements, and that this may allow for the NHS Wales to secure significant savings.

25. The witnesses at the Audit Committee hearing told us that they will take on board the Auditor General's recommendations that may help to reduce the expenditure on primary care medicines. We are confident that they are fully aware of the risks of making any changes to the existing system, but we emphasise that the Director of NHS Wales should fully examine these risks and take on board expert advice from the All-Wales Drugs Contracting Committee and the All-Wales Medicines Strategy Group in taking forward the piloting of centralised purchasing contracts.

26. We welcome the progress already made on improving prescribing behaviour and medicines management, as outlined in paragraph 4.26 of the Auditor General's report and in the evidence given by the Director of NHS Wales and the Head of the Assembly's NHS Department Pharmacy Services Branch[60]. In particular, we welcome the work being undertaken by the all-Wales Medicines Strategy Group to identify reasons for variations in levels of generic prescribing within Wales. We are also encouraged to learn that local health groups have set up prescribing incentive schemes together with GPs in their area, to monitor prescribing behaviour. We will, however, wish to see the results of the evaluations of such initiatives.

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[57] Q81
[58] Q96
[59] Q98
[60] Q68, 69, 70

Recommendations

27. In light of these findings and conclusions we recommend that:

i. **the Assembly's NHS Department monitors the differences in prices charged to the primary and secondary care sectors before making changes to the arrangements for the procurement of selected primary care medicines;**

ii. **the Assembly's NHS Department pursues centralised contracts for primary care medicines on the basis of the proposals and advice that it receives from the All-Wales Medicines Strategy Group;**

iii. **the Assembly's NHS Department assess the adequacy of the Essential Small Pharmacy Scheme as a means of addressing the potential destabilising effect of centralisation, and uses its powers to reform the Scheme if it assesses it as inadequate;**

iv. **the Assembly's NHS Department fully evaluates all its piloting of centralised contracts for primary care medicines, taking account of all costs and benefits, including the effects on access to pharmacy and GP services and the cost of buying in expertise, and that it disseminates the lessons learned before taking such contracts further;**

v. **prescribing behaviour and medicines management advances are monitored by local health boards and the Assembly's NHS Department using the new performance management framework and that the Assembly's NHS Department keep the Auditor General for Wales updated on progress;**

vi. **the Assembly's NHS Department makes full use of the work of the All-Wales Medicines Strategy Group in setting targets for generic prescribing and developing strategies for increasing the level of generic prescribing where appropriate.;**

vii. **the Assembly's NHS Department draws together the results of its evaluations of initiatives intended to improve prescribing behaviour so that they may readily be disseminated;**

viii. **the Director of NHS Wales requests that the All-Wales Medicines Strategy Group reviews the justification for prescribing medicines of limited clinical value and considers what cost-effective alternatives there may be beyond prescription, such as the provision of written dietary advice.**

Cynulliad Cenedlaethol Cymru
Pwyllgor Archwilio
The National Assembly for Wales
Audit Committee

Caffael Meddyginiaethau Gofal Sylfaenol
The Procurement of Primary Care Medicines

Cwestiynau 1-106
Questions 1-106

Dydd Iau 27 Mawrth 2003
Thursday 27 March 2003

Aelodau o'r Cynulliad yn bresennol: Dafydd Wigley (Cadeirydd), Eleanor Burnham, Alun Cairns, Janet Davies, Jocelyn Davies, Janice Gregory, Alison Halford, Ann Jones.

Swyddogion yn bresennol: Syr John Bourn, Archwilydd Cyffredinol Cymru; Frank Grogan, Swyddfa Archwilio Genedlaethol Cymru; David Powell, Swyddog Cydymffurfio Cynulliad Cenedlaethol Cymru.

Tystion: Ann Lloyd, Cyfarwyddwr GIG Cymru; Carolyn Poulter, Pennaeth y Gangen Gwasanaethau Fferyllol, Is-adran Iechyd Sylfaenol a Chymunedol, Cynulliad Cenedlaethol Cymru.

Assembly Members present: Dafydd Wigley (Chair), Eleanor Burnham, Alun Cairns, Janet Davies, Jocelyn Davies, Janice Gregory, Alison Halford, Ann Jones.

Officials present: Sir John Bourn, Auditor General for Wales; Frank Grogan, National Audit Office Wales; David Powell, National Assembly for Wales Compliance Officer.

Witnesses: Ann Lloyd, Director, NHS Wales; Carolyn Poulter, Head of Pharmaceutical Services Branch, Primary and Community Health Division, National Assembly for Wales.

Dechreuodd y cyfarfod am 9.10 a.m.
The meeting began at 9.10 a.m.

[1] **Dafydd Wigley:** Galwaf y Pwyllgor i drefn.

For the benefit of visitors, you may be aware that we work in a bilingual capacity. Members and witnesses can speak in either language, and simultaneous translation is available through the headphones. The headphones may also be helpful to those who are hard of hearing. Please ask the attendants if you want help with that.

Croesawaf bawb i'r cyfarfod hwn. Hwn yw fy nghyfarfod olaf fel Cadeirydd, a chaf gyfle i gyfeirio at hynny yn nes ymlaen. Croesawaf y tystion, Aelodau a'r cyhoedd i'r cyfarfod hwn. Atgoffaf bawb o'r angen i ddiffodd unrhyw ffonau symudol, blipwyr ac offer technegol arall a allai amharu ar y system ddarlledu.

Nid wyf wedi derbyn unrhyw ymddiheuriadau. A oes unrhyw ddatganiadau o fuddiant?

[2] **Janet Davies:** Yes, Chair. This is not a registerable interest but, because of the hearing that we have this morning, I think that I should declare that I hold some shares in two pharmaceutical companies, GlaxoSmithKline and British Biotech.

[1] **Dafydd Wigley:** I call the Committee to order.

Er gwybodaeth i ymwelwyr, efallai eich bod yn ymwybodol ein bod yn gweithio yn ddwyieithog. Gall aelodau a thystion siarad yn y naill iaith, ac mae cyfieithu ar y pryd ar gael drwy'r clustffonau. Gall y clustffonau hefyd fod yn ddefnyddiol i bobl trwm eu clyw. Gofynnwch i'r staff os ydych angen cymorth gyda hynny.

I welcome everyone to this meeting. This is my last meeting as Chair, and I will have an opportunity to refer to that later on. I welcome witnesses, Members and the public to this meeting. I remind everyone of the need to switch off any mobile phones, bleepers and other technical equipment that could interfere with the broadcasting system.

I have not received any apologies. Are there any declarations of interest?

[2] **Janet Davies:** Oes, Gadeirydd. Nid yw hwn yn fuddiant cofrestradwy ond, oherwydd y gwrandawiad sydd gennym y bore yma, credaf y dylwn ddatgan fy mod yn berchen ar rai cyfranddaliadau mewn dau gwmni fferyllol, GlaxoSmithKline a British Biotech.

[3] **Dafydd Wigley:** Okay, that has been noted. I am grateful to you for making that declaration.

I hope that we can break for coffee at about 10.45 a.m., and I hope that we will have cleared our first evidence session by then. We will see how well we are progressing.

[3] **Dafydd Wigley:** O'r gorau, mae hynny wedi ei nodi. Yr wyf yn ddiolchgar ichi am wneud y datganiad hwnnw.

Yr wyf yn gobeithio y gallwn gael egwyl am goffi tua 10.45 a.m., ac yr wyf yn gobeithio y byddwn wedi cyrraedd diwedd ein sesiwn dystiolaeth gyntaf erbyn hynny. Cawn weld sut gynnydd yr ydym yn ei wneud.

Cyn imi wahodd y tystion i gyflwyno'u hunain, hoffwn ddweud un neu ddau o eiriau o ran cefndir cyn bwrw i mewn i'r agenda fanwl. Gobeithiaf y bydd yr esboniad sy'n dilyn o gymorth i ymwelwyr ac i rai sy'n dilyn ein trafodaethau ar y teledu adref, a all fod yn anodd ar brydiau. Y prif eitem ar ein agenda heddiw yw sesiwn cymryd tystiolaeth ar adroddiad a baratowyd gan Swyddfa Archwilio Genedlaethol Cymru, 'Caffael Meddyginiaethau Gofal Sylfaenol'. Mae'n adroddiad eithaf cymhleth, oherwydd mae system y gwasanaeth iechyd gwladol o ddarparu meddyginiaethau a chyffuriau yn gymhleth ac mae'r dull o benderfynu ar y pris a delir amdanynt yn fwy cymhleth fyth. Yr ydym, felly, yn ddiolchgar iawn i swyddogion y Swyddfa Archwilio Genedlaethol ac i Archwilydd Cyffredinol Cymru, Syr John Bourn, am eu gwaith ymchwil manwl dros fisoedd lawer, sydd wedi esgor ar yr adroddiad sydd ger ein bron heddiw. Mae'r adroddiad wedi'i gytuno o ran ffeithiau gan swyddogion y swyddfa archwilio ar y naill law a chan weision sifil y gwasanaeth iechyd gwladol yng Nghymru ar y llaw arall.

Before I invite the witnesses to introduce themselves, I would like to say one or two words in terms of the background before we move on to the detailed agenda. I hope that the following explanation will be of help to visitors and to those who are following our discussions on the television at home, which can be difficult at times. The main item on our agenda today is the evidence-taking session on a report prepared by the National Audit Office Wales, 'The Procurement of Primary Care Medicines'. The report is quite complex, because the national health service's system of providing medicines and drugs is complex and the method of deciding on the price is even more complex. We are, therefore, very grateful to National Audit Office officials and to the Auditor General for Wales, Sir John Bourn, for their detailed research work over many months, which has led to the drawing up of the report that is before us. The facts included in the report have been agreed upon by audit office officials on the one hand, and by civil servants of the national health service in Wales on the other.

Ein prif dystion, y byddaf yn gofyn wrthynt gyflwyno'u hunain mewn eiliad, yw penaethiaid y gwasanaeth iechyd gwladol yng Nghymru. Hwy sydd, felly, yn gyfrifol am y meysydd hyn o safbwynt cynnal gwasanaeth a hefyd o safbwynt gweithredu o fewn cyllideb a sicrhau gwerth gorau am arian cyhoeddus. Mae swm sylweddol o arian yn y fantol. Mae meddyginiaethau yn cynrychioli 15 y cant o gost y gwasanaeth iechyd gwladol yng Nghymru, ac mae hynny'n gyfystyr â thros £400 miliwn y flwyddyn. Pe baem mewn sefyllfa i arbed 10 y cant o'r gost honno hyd yn oed, naill ai drwy sicrhau prisiau mwy ffafriol neu drwy ddefnydd mwy effeithiol o gyffuriau, byddai

Our main witnesses, whom I will ask to introduce themselves in a second, head the national health service in Wales. They are the ones, therefore, who are responsible for these areas in terms of maintaining service and also in terms of operating within budget and ensuring best value for public money. A significant amount of money is at stake. Medicines form 15 per cent of the cost of the national health service in Wales, and that is equivalent to over £400 million a year. Were we in a position to save even 10 per cent of that cost, either by ensuring more favourable prices or by the more effective use of drugs, that would save £40 million that could be used to employ more doctors, nurses or

hynny'n arbed £40 miliwn y gellid ei ddefnyddio i gyflogi mwy o ddoctoriaid, nyrsys neu therapyddion. Mae'n amlwg felly bod hwn yn fater difrifol.

therapists. It is evident therefore that this is a serious matter.

Mae'r adroddiad yn tynnu sylw at £97 miliwn o wariant y gellid efallai ei arbed—pwysleisiaf y gair 'efallai' oherwydd dyna fydd testun rhai o'r cwestiynau y byddwn yn eu holi. Mae'r adroddiad yn rhybuddio y byddai rhai peryglon o newid y drefn a rhai anawsterau wrth geisio gwireddu arbedion.

The report draws attention to £97 million of expenditure that could perhaps be saved—I emphasise the word 'perhaps' because that will be the subject of some of the questions that we will ask. The report warns that there would be some risks in changing the system and some difficulties in trying to realise savings.

Y cwestiynau y byddwn ni, fel Pwyllgor, eisiau eu holi felly fydd rhai i ganfod faint o arian, mewn gwirionedd, y gellid ei arbed, a ydyw'n ymarferol sicrhau'r arbedion hynny a sut fath o amserlen sydd ar gyfer hyn. Yn sgîl y gwrandawiad, byddwn yn cyhoeddi adroddiad ac ynddo argymhellion i Lywodraeth Cymru yn seiliedig ar y dystiolaeth.

The questions that we, as a Committee, will want to ask therefore will be ones to determine how much money could, in reality, be saved, whether achieving those savings is practicable, and what kind of timetable exists for this. As a result of the hearing, we will publish a report that will include recommendations to the Government of Wales based on the evidence.

Symudwn ymlaen felly at y cwestiynau, a gwahoddaf ein tystion i gyflwyno'u hunain.

We will therefore move on to the questions, and I invite our witnesses to introduce themselves.

Ms Lloyd: I am Ann Lloyd, the director of NHS Wales.

Ms Lloyd: Fi yw Ann Lloyd, cyfarwyddwr GIG Cymru.

Ms Poulter: I am Carolyn Poulter, the head of the pharmaceutical services branch in the Assembly. I am also a registered pharmacist.

Ms Poulter: Fi yw Carolyn Poulter, pennaeth y gangen gwasanaethau fferyllol yn y Cynulliad. Yr wyf hefyd yn fferyllydd cofrestredig.

[4] **Dafydd Wigley:** Diolch yn fawr. Agoraf y sesiwn drwy ofyn cwestiwn wrthych chi, Ann Lloyd. Mae'r gyfundrefn a'r trefniadau ar gyfer caffael meddyginiaethau gofal sylfaenol yn ymddangos yn eithriadol o gymhleth. Am ba reswm y mae hynny?

[4] **Dafydd Wigley:** Thank you. I will open the session by asking a question to you, Ann Lloyd. The system and the arrangements for procuring primary care medicines appear to be extremely complex. What is the reason for that?

Ms Lloyd: I think that that is because we are dealing with 1,000 individual contractors who are all buying medicines on our behalf to either prescribe or dispense to individual patients. These are independent and that, I think, is the greatest difference between the primary care sector and the secondary care sector, in that the secondary care prescribers are employees of the national health service and the general practitioners and pharmacists out in the community are not. Also, there seems to have been, as you quite rightly said,

Ms Lloyd: Credaf fod hynny oherwydd ein bod yn delio â 1,000 o gontractwyr unigol sydd i gyd yn prynu meddyginiaethau ar ein rhan naill ai i'w rhagnodi neu'u dosbarthu i gleifion unigol. Mae'r rhain yn annibynnol a dyna, yn fy marn i, yw'r gwahaniaeth mwyaf rhwng y sector gofal sylfaenol a'r sector gofal eilaidd, sef bod y rhagnodwyr gofal eilaidd yn cael eu cyflogi gan y gwasanaeth iechyd gwladol ond nid yw hyn yn wir am y meddygon teulu a'r fferyllwyr yn y gymuned. Hefyd, mae'n ymddangos y bu, fel y

some extremely complex negotiations around how drugs for the primary care service are procured and the systems of discounts and reimbursements and the way in which, if pharmacists dispense at an increasing rate in terms of value, then their profit margins are reduced. There seems to have been, in the prescribing formulary—the drug tariff—an extraordinarily complex set of inter-related circumstances, which therefore guide the price that we are paying for drugs. The Auditor General, I think quite rightly, points out how complicated all this is and the risks of changing it, although I am wholehearted in a desire to ensure that we get value for money and, where we can possibly do so, reduce the costs of prescribing, which are going up exponentially year by year. It has certainly caused quite a difficult problem for us in the NHS, particularly this year, where the percentage has increased to about 12 per cent above last year's rates in terms of value, and we only generally give 9 per cent uplift per year to health authorities. That has caused a big problem for us all to manage. Nevertheless, I think that we need to weigh the risks that the Auditor General has very carefully pointed out to us in trying to use really good practice, which we are trying to do in Wales, and weigh the checks, balances, risks and advantages to us in trying to get more stabilisation and more central control on the prescribing and dispensing of primary care drugs.

dywedasoch yn hollol gywir, rhai negodiadau tu hwnt o gymhleth am sut caiff cyffuriau ar gyfer y gwasanaeth gofal sylfaenol eu caffael a'r systemau gostyngiadau ac ad-daliadau a'r modd y mae elw fferyllwyr yn lleihau os ydynt yn dosbarthu ar raddfa gynyddol o safbwynt gwerth. Mae'n ymddangos y bu, yn y cyffurlyfr rhagnodi—rhestr brisiau'r cyffuriau—gyfres eithriadol o gymhleth o amgylchiadau rhyngberthynol, sydd felly'n arwain y pris yr ydym yn ei dalu am gyffuriau. Mae'r Archwilydd Cyffredinol, yn llygad ei le yn fy marn i, yn nodi pa mor gymhleth yw hyn i gyd a'r peryglon o newid y drefn, er fy mod i'n frwd fy nymuniad i sicrhau ein bod yn cael gwerth am arian a, lle mae'n bosibl inni wneud hynny, lleihau costau rhagnodi, sy'n codi'n gynt flwyddyn ar ôl blwyddyn. Mae'n sicr wedi achosi problem eithaf anodd i ni yn y GIG, yn enwedig eleni, lle mae'r ganran wedi codi i tua 12 y cant yn uwch na chyfraddau y llynedd o safbwynt gwerth, ac yr ydym ond yn rhoi cynnydd o 9 y cant y flwyddyn i awdurdodau iechyd yn gyffredinol. Mae hynny wedi achosi problem fawr i ni oll i'w rheoli. Serch hynny, credaf fod angen inni bwyso a mesur y risgiau mae'r Archwilydd Cyffredinol wedi eu hamlygu inni yn ofalus o geisio defnyddio arferion da iawn, yr ydym yn ceisio ei wneud yng Nghymru, a phwyso a mesur y gwiriadau, mantolenni, peryglon a manteision i ni o geisio cael mwy o sefydlogrwydd a mwy o reolaeth ganolog dros y gwaith o ragnodi a dosbarthu cyffuriau gofal sylfaenol.

[5] **Dafydd Wigley:** In underlining, quite rightly, the complexity and the risks that may be associated with change, would you accept that there is still scope for improving procurement arrangements in Wales?

[5] **Dafydd Wigley:** O danlinellu, yn hollol gywir, y cymhlethdod a'r peryglon a allai fod yn gysylltiedig â newid, a fyddech yn derbyn bod lle o hyd i wella trefniadau caffael yng Nghymru?

Ms Lloyd: Yes, I do. I think that when we all read this report very carefully, there are obvious areas of good practice that are pointed out to us by the Auditor General and which we indeed have been pursuing. I think that, with the advent of more local control through the local health boards—and you have seen what some of the local health groups have already been doing in terms of formularies and persuasion, in trying to get better deals and in the substitution of generics from the doctors' prescribing practice—there

Ms Lloyd: Ydw, yr ydwyf. Credaf pan fyddwn oll yn darllen yr adroddiad hwn yn ofalus iawn, mae meysydd amlwg o arferion da y mae'r Archwilydd Cyffredinol wedi eu dwyn i'n sylw ac yr ydym yn wir wedi bod ar eu trywydd. Credaf, gyda dyfodiad mwy o reolaeth leol drwy'r byrddau iechyd lleol—ac yr ydych wedi gweld beth mae rhai o'r grwpiau iechyd lleol eisoes wedi bod yn ei wneud o ran cyffurlyfrau a pherswâd, wrth geisio cael bargeinion gwell ac wrth amnewid cyffuriau generig o arferion rhagnodi

is much more that we can do to spread that good practice and to test the local health boards on how they have adopted the helpful approach outlined in this report.

meddygon—mae llawer mwy y gallwn ei wneud i ledaenu arferion da ac i brofi'r byrddau iechyd lleol ar sut maent wedi mabwysiadu'r dull defnyddiol sy'n cael ei amlinellu yn yr adroddiad hwn.

[6] **Dafydd Wigley:** I am grateful for that. Eleanor?

[6] **Dafydd Wigley:** Yr wyf yn ddiolchgar am hynny. Eleanor?

[7] **Eleanor Burnham:** Paragraph 2.16 states that the Assembly does not have powers to change the pharmaceutical price regulation scheme, otherwise known as PPRS—I am only saying that in case anyone is listening and wondering what all these acronyms are—but that it may be able to influence the actions of the Department of Health. What influence do you have with the Department of Health so as to ensure that this PPRS is a good deal for Wales?

[7] **Eleanor Burnham:** Mae paragraff 2.16 yn nodi nad oes gan y Cynulliad bwerau i newid y cynllun rheoleiddio prisiau fferyllol, PPRS fel y'i gelwir—yr wyf ond yn dweud hynny rhag ofn fod rhywun yn gwrando ac yn pendroni beth yw'r holl acronymau hyn—ond y gallai efallai ddylanwadu ar gamau gweithredu yr Adran Iechyd. Pa ddylanwad sydd gennych yn yr Adran Iechyd i sicrhau bod y PPRS hwn yn gytundeb da i Gymru?

Ms Lloyd: We have a very close and positive working relationship with the Department of Health, because this is a universal issue and the Department of Health is operating on behalf of all the countries in the United Kingdom. It is felt better that that is the way it is done, because we then have much more leverage and much more purchasing power and ability to influence the decision universally on the pharmaceutical companies. It makes sure that we are not disadvantaged, because we are relatively small compared with England, and even Scotland, in terms of their purchasing power. So, we have continued to work very closely with the department and we are full partners in all the reviews that are being undertaken at the moment into this area.

Ms Lloyd: Mae gennym berthynas waith dda ac agos iawn gyda'r Adran Iechyd, oherwydd mae hwn yn fater cyffredinol ac mae'r Adran Iechyd yn gweithredu ar ran holl wledydd y Deyrnas Unedig. Teimlir ei bod yn well mai dyna'r modd y caiff ei wneud, oherwydd wedyn mae gennym lawer mwy o ddylanwad a llawer mwy o rym prynu a gallu i ddylanwadu ar y penderfyniad yn gyffredinol ar y cwmnïau fferyllol. Mae'n sicrhau nad ydym o dan anfantais, oherwydd yr ydym yn gymharol fach o'n cymharu â Lloegr, a hyd yn oed yr Alban, o ran eu grym prynu. Felly, yr ydym wedi parhau i weithio'n agos iawn gyda'r adran ac yr ydym yn bartneriaid llawn yn yr holl adolygiadau sy'n cael eu cynnal ar hyn o bryd yn y maes hwn.

[8] **Eleanor Burnham:** But, from our knowledge, there is obviously a lot more ill health in Wales and perhaps specific illnesses, particularly in the Valleys, ensuing from the post-industrial period. Do you see any way in which your influence could be strengthened so that, perhaps, if there are specific needs in Wales, they could be addressed to a greater extent?

[8] **Eleanor Burnham:** Ond, o'n gwybodaeth ni, mae'n amlwg bod llawer mwy o afiechyd yng Nghymru ac efallai afiechydon penodol, yn enwedig yn y Cymoedd, yn deillio o'r cyfnod ôl-ddiwydiannol. A ydych yn gweld unrhyw fodd y gellid cynyddu'ch dylanwad fel, efallai, os oes anghenion penodol yng Nghymru, y gellid mynd i'r afael â hwy i raddau ehangach?

Ms Lloyd: I think that we should not be south-east England centric. There are lots of areas of considerable ill health in England as well.

Ms Lloyd: Credaf na ddylem ganolbwyntio ar dde-ddwyrain Lloegr. Mae llawer o ardaloedd o afiechyd sylweddol yn Lloegr hefyd.

[9] **Eleanor Burnham:** But they might be different types of illnesses.

Ms Lloyd: They are not necessarily different types of illnesses. Illnesses borne out of an industrial heritage are fairly prevalent in England as well. Nevertheless, we have very good health needs assessment data in Wales, as they do in Scotland, and we work very closely with colleagues in Scotland too to ensure that the full requirements of our population are borne in mind in any negotiations undertaken by the Department of Health.

[10] **Dafydd Wigley:** I turn now to the part of the report that deals with the potential for reducing the cost of medicine procurement by adopting a different tariff for drugs and by various degrees of more centralised purchasing. The savings indicated in paragraph 3.8 suggest that centralised contracts are worth pursuing. Do you plan to take this option forward and, if you are to centralise contracts in order to get more leverage over the prices, would it be at a district level or at an all-Wales level?

Ms Lloyd: I think, basically, that, yes, of course we will pursue the piloting of central contracts for primary care. We are very happy to consider that. There are a number of arguments for centralised purchasing and local purchasing and those have been rehearsed. The all-Wales medicines strategy group, which has recently been established, arising from the task and finish group that first highlighted this issue of primary care prescribing, will be giving us advice and guidance and looking very thoroughly at the types of pilot schemes that we can pursue within the next six months. The local health board pilot schemes that we could pursue are unlikely to destabilise the national arrangements. However, we might have an increased risk in terms of supply, which I think is important, because one of the big problems in terms of suppliers is that if you put all your eggs in one basket and suddenly the person goes out of business, then the production of the drug might have ceased elsewhere and you really are placing yourself in a vulnerable position. We have to evaluate the balance of risk throughout that sort of

[9] **Eleanor Burnham:** Ond efallai eu bod yn fathau gwahanol o afiechydon.

Ms Lloyd: Nid ydynt o reidrwydd yn fathau gwahanol o afiechydon. Mae afiechydon sy'n deillio o orffennol diwydiannol yn eithaf cyffredin yn Lloegr hefyd. Serch hynny, mae gennym ddata asesu anghenion iechyd da iawn yng Nghymru, fel sydd ganddynt yn yr Alban, ac yr ydym yn cydweithio'n agos iawn â chydweithwyr yn yr Alban hefyd i sicrhau bod gofynion llawn ein poblogaeth yn cael eu hystyried mewn unrhyw drafodaethau sy'n cael eu cynnal gan yr Adran Iechyd.

[10] **Dafydd Wigley:** Trof yn awr at y rhan o'r adroddiad sy'n ymwneud â'r potensial i leihau'r gost o gaffael meddyginiaeth drwy fabwysiadu rhestr brisiau wahanol ar gyfer cyffuriau a thrwy wahanol raddau o brynu mwy canolog. Mae'r arbedion a nodir ym mharagraff 3.8 yn awgrymu ei bod hi'n werth mynd ar drywydd contractau canolog. A ydych yn bwriadu datblygu'r opsiwn hwn ac, os ydych am ganoli contractau er mwyn cael mwy o ddylanwad ar y prisiau, a fyddai hyn ar lefel dosbarth neu ar lefel Cymru gyfan?

Ms Lloyd: Credaf, yn y bôn, y byddwn, wrth gwrs, yn mynd ar drywydd cynnal cynllun peilot o'r contractau canolog ar gyfer gofal sylfaenol. Yr ydym yn fodlon iawn ystyried hynny. Mae nifer o ddadleuon dros brynu canolog a phrynu lleol ac mae'r rheini wedi cael eu lleisio. Bydd grŵp strategaeth meddyginiaethau Cymru gyfan, a sefydlwyd yn ddiweddar, yn deillio o'r grŵp gorchwyl a gorffen a dynnodd sylw at y mater hwn o ragnodi gofal sylfaenol yn y lle cyntaf, yn rhoi cyngor a chanllawiau inni ac yn edrych yn ofalus iawn ar y mathau o gynlluniau peilot y gallwn eu mabwysiadu yn y chwe mis nesaf. Mae cynlluniau peilot y byrddau iechyd lleol y gallem eu mabwysiadu yn annhebygol o ddadsefydlogi'r trefniadau cenedlaethol. Fodd bynnag, efallai fod mwy o berygl i ni o ran cyflenwad, sy'n bwysig yn fy marn i, oherwydd un o'r problemau mawr o ran cyflenwyr yw os ydych yn rhoi'ch wyau i gyd yn yr un fasged ac yn sydyn bod busnes yr unigolyn hwnnw'n methu, yna mae'n bosibl fod y gwaith o gynhyrchu'r cyffur wedi dod i ben yn rhywle arall a'ch bod yn rhoi'ch hun mewn sefyllfa wan. Rhaid

thing. However, it really could influence local prescribing behaviour and, if we are targeting areas of particular ill health where the drugs budget is extremely high, then a more localised approach could be the best way forward. However, we need time to establish those organisations and to grow the behaviour, which will ensure that local formularies are effective and are owned by the GPs and others. So, that, on one side, is the local issue. In terms of the more centralised contracting pilot schemes, I think that we would have to be careful about what we chose to try to negotiate on a centralised basis because it is highly complex to negotiate some of these purchases. It has not been so bad in the secondary care sector where you are really only looking at approximately 500 items. The number is 14,000 in primary care.[i] So, in order not to disperse our energies, and to really get the savings that we would hope to achieve, I think that we would have to limit the centralised purchasing pilot scheme to a few of the most regularly used drugs, those that are probably suitable for generic prescribing. We would have to be careful that there is a suitable generic substitute available to us. We—Carolyn, particularly, and Carwen Wynne Howells, our chief pharmacist—have put this test to the all-Wales medicines strategy group to come forward with a proposal to us so that we can start to undertake pilot schemes with the agreement of the contracting community.[ii]

inni werthuso cybwysedd y risg drwy gydol y math hwnnw o beth. Fodd bynnag, gallai'n wir ddylanwadu ar ymddygiad rhagnodi lleol ac, os ydym yn targedu meysydd o afiechyd penodol lle mae'r gyllideb gyffuriau yn hynod uchel, yna mae'n bosibl mai dull mwy lleol fyddai'r ffordd orau ymlaen. Fodd bynnag, mae angen amser arnom i sefydlu'r sefydliadau hynny ac i ddatblygu'r ymddygiad, a fydd yn sicrhau bod cyffurlyfrau lleol yn effeithiol a'u bod yn eiddo i feddygon teulu ac eraill. Felly, dyna, ar un ochr, yw'r ddadl leol. O safbwynt y cynlluniau peilot contractio mwy canolog, credaf y byddai'n rhaid inni fod yn ofalus ynglŷn â'r hyn y byddem yn ei ddewis i geisio negodi yn ganolog oherwydd mae'n gymhleth iawn negodi rhai o'r pryniadau hyn. Nid yw wedi bod cynddrwg yn y sector gofal eilaidd lle'r ydych ond yn edrych ar tua 500 o eitemau mewn gwirionedd. Mae'r nifer yn 14,000 mewn gofal sylfaenol.[i] Felly, er mwyn peidio â gwasgaru ein hymdrechion, ac i gael yr arbedion y byddem yn gobeithio eu sicrhau mewn gwirionedd, credaf y byddai'n rhaid inni gyfyngu ar y cynllun peilot prynu canolog i rai o'r cyffuriau a ddefnyddir yn fwyaf rheolaidd, y rheini sydd yn ôl pob tebyg yn addas ar gyfer rhagnodi generig. Byddai'n rhaid inni fod yn ofalus bod cyffur amgen generig addas ar gael i ni. Yr ydym—Carolyn, yn enwedig, a Carwen Wynne Howells, ein prif fferyllydd—wedi rhoi'r prawf hwn i'r grŵp strategaeth meddyginiaethau Cymru gyfan i gyflwyno cynnig i ni fel y gallwn ddechrau cynnal cynlluniau peilot gyda chaniatâd y gymuned contractio.[ii]

[11] **Dafydd Wigley:** That is very encouraging. If I understand correctly, you are saying that over the next six months or so, you will be developing a number of pilot schemes, not just one, and that there will be some local ones and some central ones.

[11] **Dafydd Wigley:** Mae hynny'n galonogol iawn. Os deallaf yn iawn, yr ydych yn dweud y byddwch, dros y chwe mis nesaf yn fras, yn datblygu nifer o gynlluniau peilot, nid un yn unig, ac y bydd rhai lleol a rhai canolog.

Ms Lloyd: We will be developing the methodology on which we will run those pilot schemes.

Ms Lloyd: Byddwn yn datblygu'r fethodoleg y byddwn yn ei defnyddio i gynnal y cynlluniau peilot hynny.

[12] **Dafydd Wigley:** Yes, and then, after, say, a six-month period of doing that, the pilot schemes could be rolled out. With regard to the local ones, do you see the local health groups actually taking the lead in

[12] **Dafydd Wigley:** Iawn, ac yna, ar ôl, dywedwch, cyfnod chwe mis o wneud hynny, gellid cyflwyno'r cynlluniau peilot. O ran y rhai lleol, a ydych yn rhagweld y bydd y grwpiau iechyd lleol mewn gwirionedd yn

negotiations where there are pilot schemes on a local level, or not? Will they have the clout, the leverage and the expertise to do that?

arwain y negodiadau lle mae cynlluniau peilot yn lleol, ai peidio? A fydd ganddynt y grym, y dylanwad a'r arbenigedd i wneud hynny?

Ms Lloyd: I think that anybody would have difficulty in negotiating with major pharmaceutical companies on their own. I think that even the full force of the National Assembly will require some very specialist advice to help it with these negotiations because the pharmaceutical companies have to be able to see that there is something in it for them as well, and also to ensure that we do not destabilise the arrangements that we also have with secondary care. Some of those arrangements are almost loss leaders, and we would have to make sure that the balance was held. So, we would need some expert advice for a central or a local pilot scheme.

Ms Lloyd: Credaf y byddai unrhyw un yn cael anhawster negodi gyda chwmnïau fferyllol mawr ar ei ben ei hun. Credaf y bydd angen rhywfaint o gyngor arbenigol iawn hyd yn oed ar holl rym y Cynulliad Cenedlaethol i'w gynorthwyo gyda'r negodiadau hyn oherwydd mae'r cwmnïau fferyllol wedi llwyddo i weld bod rhywfaint o fudd yn hyn iddynt hwythau hefyd, a hefyd i sicrhau nad ydym yn dadsefydlogi'r trefniadau sydd gennym hefyd gyda gofal eilaidd. Mae rhai o'r trefniadau hynny bron yn rhai ar golled, a byddai'n rhaid inni sicrhau bod y cydbwysedd yn cael ei gynnal. Felly, byddai angen rhywfaint o gyngor arbenigol arnom ar gyfer cynllun peilot canolog neu leol.

[13] **Dafydd Wigley:** Alun, you want to come in on this. You are not going to ask a question that is to be asked later on are you?

[13] **Dafydd Wigley:** Alun, yr ydych am ddod i mewn yn y fan hon. Nid ydych yn mynd i ofyn cwestiwn sy'n mynd i gael ei ofyn yn nes ymlaen ydych chi?

[14] **Alun Cairns:** I hope not. I will be brief, Cadeirydd. Ms Lloyd, in terms of changing the methodology for these pilot schemes, or in developing it—particularly for those pilot schemes relating to the health boards, where they can strike local arrangements—can you advise us as to whether you would include the cost implications of buying in the expertise for the local health boards, because, with the greatest respect, bearing in mind that they are such new bodies, I hardly think that that hard-headed negotiating expertise would already exist within them?

[14] **Alun Cairns:** Nac ydwyf gobeithio. Byddaf yn fyr, Gadeirydd. Ms Lloyd, o ran newid y fethodoleg ar gyfer y cynlluniau peilot hyn, neu ei datblygu—yn enwedig ar gyfer y cynlluniau peilot hynny sy'n ymwneud â'r byrddau iechyd, lle gallant wneud trefniadau lleol—a allwch ddweud wrthym a fyddech yn cynnwys y goblygiadau cost o brynu'r arbenigedd ar gyfer y byrddau iechyd lleol, oherwydd, gyda phob parch, o ystyried eu bod yn gyrff mor newydd, nid oes bosibl y byddai'r arbenigedd negodi craff hynny eisoes yn bodoli ganddynt yn fewnol?

Ms Lloyd: Yes, of course you would, because all pilot schemes must be evaluated against their full cost. Whenever we embark on pilot schemes of this or any nature in my department, we always ensure that the costs of establishing and evaluating the pilot scheme are included. I think that the issue surrounding the local health boards and where they may have a greater influence at the end of the day—and this is subject to my speculation—is that they may have a closer involvement in changing behaviour, which is absolutely fundamental to the success of any

Ms Lloyd: Byddech, wrth gwrs, oherwydd rhaid gwerthuso pob cynllun peilot yn erbyn eu cost lawn. Pryd bynnag yr ydym yn cychwyn ar gynlluniau peilot o'r math hwn neu o unrhyw fath yn fy adran i, yr ydym bob amser yn sicrhau bod costau sefydlu a gwerthuso'r cynllun peilot yn cael eu cynnwys. Credaf mai'r mater ynglŷn â'r byrddau iechyd lleol a lle mae'n bosibl iddynt gael mwy o ddylanwad yn y pen draw—ac mae hyn yn amodol ar fy nhybiaeth i—yw efallai y byddant yn ymwneud yn agosach â newid ymddygiad, sy'n hollol

pilot scheme, be it a central or a local pilot scheme.

hanfodol i lwyddiant pob cynllun peilot, boed yn gynllun peilot canolog neu leol.

[15] **Dafydd Wigley:** Eleanor, do you want to ask a brief question on this?

[15] **Dafydd Wigley:** Eleanor, a ydych am ofyn cwestiwn byr am hyn?

[16] **Eleanor Burnham:** We are also, are we not, Ms Lloyd, dealing with the issue—you talk about stabilisation and not destabilising the scenario—of community pharmacists, who are extremely worried now that they are going to be in a very weakened position and that they may literally be vacuumed up by the buying power of supermarkets if they are allowed to come on-stream? That could destabilise the situation.

[16] **Eleanor Burnham:** Yr ydym hefyd, onid ydym, Ms Lloyd, yn delio â mater—soniwch am sefydlogi a pheidio â dadsefydlogi'r sefyllfa—fferyllwyr cymuned, sy'n pryderu'n fawr bellach eu bod yn mynd i fod mewn sefyllfa lawer gwannach ac y cânt efallai, yn llythrennol, eu llyncu gan rym prynu'r archfarchnadoedd os y caniateir iddynt ymuno? Gallai hynny ddadsefydlogi'r sefyllfa.

Ms Lloyd: Well, as you know, the Minister made a statement about that issue yesterday. However, basically, what we would have to do in all these pilot schemes is have a thorough understanding of all the risks and the advantages and test those thoroughly. The report helpfully outlines the issues of the rural nature of some of this practice, and the risks surrounding destabilising, particularly in the rural areas.

Ms Lloyd: Wel, fel y gwyddoch, gwnaeth y Gweinidog ddatganiad am y mater hwnnw ddoe. Fodd bynnag, yn y bôn, yr hyn y byddai'n rhaid i ni ei wneud yn yr holl gynlluniau peilot hyn yw cael dealltwriaeth drylwyr o'r holl risgiau a'r manteision a phrofi'r rheini'n drylwyr. Mae'r adroddiad yn ddefnyddiol yn amlinellu'r materion o natur wledig rhywfaint o'r arfer hwn, a'r risgiau sy'n gysylltiedig â dadsefydlogi, yn enwedig yn yr ardaloedd gwledig.

[17] **Dafydd Wigley:** We may come back to that later. Ann?

[17] **Dafydd Wigley:** Efallai y deuwn yn ôl at hynny nes ymlaen. Ann?

[18] **Ann Jones:** We are still on paragraph 3.8. That paragraph, and figure 6 in particular, indicates that a few high-volume items account for the bulk of what could be a calculated saving. The report refers to them as the 'top 10'. The savings indicated in figure 6 seem to indicate that the NHS is currently not getting a good deal on some of these top 10 items. I will not attempt to tell you what the items are—I am sure that they have given this question to me on purpose. I apologise to those of you who do not have the report, but I suggest that you try to find a copy, because I will not even attempt to pronounce them. Do you think that it is a fair assessment in the auditor's report that almost £23 million in savings could be made on those top 10 drugs?

[18] **Ann Jones:** Yr ydym yn dal ar baragraff 3.8. Mae'r paragraff hwnnw, a ffigur 6 yn arbennig, yn nodi bod rhai eitemau swm uchel yn cyfrif am y rhan fwyaf o beth allai fod yn arbediad amcangyfrifedig. Cyfeiria'r adroddiad atynt fel y '10 uchaf'. Mae'n ymddangos bod yr arbedion a nodir yn ffigur 6 yn nodi nad yw'r GIG yn cael cytundeb da ar hyn o bryd ar rai o'r 10 eitem uchaf hyn. Ni cheisiaf ddweud wrthych beth yw'r eitemau hyn—yr wyf yn siŵr eu bod wedi rhoi'r cwestiwn hwn imi yn fwriadol. Ymddiheuraf i'r rheini ohonoch nad oes gennych yr adroddiad, ond awgrymaf eich bod yn ceisio dod o hyd i gopi, oherwydd ni wnaf i hyd yn oed ceisio eu hynganu. A gredwch ei fod yn asesiad teg yn adroddiad yr archwilydd y gellid arbed bron i £23 miliwn ar y 10 cyffur uchaf hynny?

Ms Lloyd: Could I ask Carolyn to answer this, because she knows the detail of these particular drugs?

Ms Lloyd: A allwn i ofyn i Carolyn ateb hwn, oherwydd mae hi'n gwybod manylion y cyffuriau penodol hyn?

[19] **Dafydd Wigley:** Yes. Carolyn?

Ms Poulter: The pharmaceutical industry would be keen to point out that discounting to secondary care is purely discretionary on its part. It reflects the fact that the expenditure on drugs in secondary care is far smaller than that in primary care. It is also based on the assumption that one hospital prescription or recommendation will generate some 15 prescriptions in primary care, so there is an incentive to encourage secondary care to prescribe a particular company's drugs. Under the PPRS, the industry's overall profits are controlled, rather than the prices of the actual drugs. So, there is room for cross-subsidisation, if you like, between prices. So, the overall cost to the NHS should not be any greater because the theory is that if the pharmaceutical industry gives a discount to secondary care, it will not lose out in terms of profit, by shifting the price to primary care. It has been suggested that discounting rates in secondary care are falling following some legal challenges and also due to the introduction of the unified budget, whereby people are far more aware of the influence of secondary care prescribing on primary care, and so there is a move by hospitals to move away from this loss-leader situation. Obviously, the pharmaceutical industry needs to recoup its development costs before the expiry of a patent.

The drugs that are highlighted in this report account for some 10 per cent of the primary care drugs spend in 2002. Half of those drugs that are mentioned are within the top 10 of primary care expenditure, so, obviously, there is greater scope for the pharmaceutical industry to provide discounts on that because of the vast numbers of drugs that are prescribed.

Obviously, attempts to extend centralised purchasing may lead to a scrapping of these discounts to secondary care so, while there is potential perhaps to make savings, the report does it make it very clear that there are risks involved, and we could actually lose this benefit to the NHS.

[20] **Dafydd Wigley:** Before Ann goes on to the next bit, may I come in and press you a

[19] **Dafydd Wigley:** Gallwch. Carolyn?

Ms Poulter: Byddai'r diwydiant fferyllol yn awyddus i bwysleisio bod rhoi gostyngiadau i ofal eilaidd yn hollol ddewisol ar ei ran ef. Mae'n adlewyrchu'r ffaith bod y gwariant ar gyffuriau mewn gofal eilaidd llawer yn is nag y mae mewn gofal sylfaenol. Mae hefyd yn seiliedig ar y dybiaeth y bydd un argymhelliad neu bresgripsiwn ysbyty yn arwain at ryw 15 presgripsiwn mewn gofal sylfaenol, felly mae cymhelliant i annog gofal eilaidd i ragnodi cyffuriau cwmni penodol. Dan y PPRS, rheolir elw cyffredinol y diwydiant, yn hytrach na phrisiau'r cyffuriau eu hunain. Felly, mae lle i groes-gymorthdalu, os hoffwch chi, rhwng prisiau. Felly, ni ddylai'r gost gyffredinol i'r GIG fod tamaid yn uwch oherwydd y ddamcaniaeth yw, os yw'r diwydiant fferyllol yn rhoi gostyngiad i ofal eilaidd, ni fydd ar ei golled o ran elw, drwy symud y pris i ofal sylfaenol. Awgrymwyd bod cyfraddau gostyngiadau mewn gofal eilaidd yn disgyn yn dilyn ambell her cyfreithiol a hefyd oherwydd cyflwyno'r gyllideb unedig, sy'n golygu bod pobl yn llawer mwy ymwybodol o ddylanwad rhagnodi gofal eilaidd ar ofal sylfaenol, ac felly mae ysbytai yn gwneud ymgais i symud i ffwrdd o'r sefyllfa 'ar golled' hon. Yn amlwg, mae angen i'r diwydiant fferyllol adennill ei gostau datblygu cyn bod patent yn dod i ben.

Mae'r cyffuriau sydd wedi'u hamlygu yn yr adroddiad hwn yn cyfrif am ryw 10 y cant o'r hyn a wariwyd ar gyffuriau mewn gofal sylfaenol yn 2002. Mae hanner y cyffuriau hynny sy'n cael eu crybwyll yn y 10 uchaf o wariant gofal sylfaenol, felly, yn amlwg, mae mwy o gyfle i'r diwydiant fferyllol ddarparu gostyngiadau ar hynny oherwydd y niferoedd helaeth o gyffuriau sy'n cael eu rhagnodi.

Yn amlwg, mae'n bosibl y gallai ymdrechion i ehangu prynu canolog arwain at ddiddymu'r gostyngiadau hyn i ofal eilaidd felly, tra bod potensial efallai i wneud arbedion, mae'r adroddiad yn ei gwneud yn glir iawn bod risgiau ynghlwm wrth hyn, ac y gallem mewn gwirionedd golli'r budd hwn i'r GIG.

[20] **Dafydd Wigley:** Cyn i Ann fynd ymlaen i'r rhan nesaf, a gaf fi ddod i mewn a'ch holi

bit further on that? Given the Napp case, where a company was fined £2 million, I think, for loss-leading, is there not already a move away from that? Do companies not realise that, if there was a question of serious loss-leading and distortion, they could be open to prosecution?

ymhellach am hynny? O gofio achos Napp, lle cafodd cwmni ddirwy o £2 miliwn, yr wyf yn credu, am werthu 'ar golled', onid oes eisoes symudiad i ffwrdd oddi wrth hynny? Onid yw cwmnïau'n sylweddoli, os oedd cwestiwn o werthu ar golled neu gamarwain difrifol, y gallent fod yn agored i gael eu herlyn?

Ms Poulter: Absolutely, and that is why discounts to secondary care have been reduced and the all-Wales drugs contracting committee, which forms centralised contracts, is actually making a positive move to avoid drugs that are obviously loss-leaders, where there is an obvious difference between primary and secondary care.

Ms Poulter: Yn bendant, a dyna pham mae gostyngiadau i ofal eilaidd wedi eu lleihau ac mae pwyllgor contractio cyffuriau Cymru gyfan, sy'n ffurfio contractau canolog, mewn gwirionedd yn cymryd cam cadarnhaol i osgoi cyffuriau sydd yn amlwg yn rhai ar golled, lle mae gwahaniaeth amlwg rhwng gofal sylfaenol ac eilaidd.

[21] **Dafydd Wigley:** So this is a valid base here, these that are listed? They are not distorted by loss-leading at this point in time?

[21] **Dafydd Wigley:** Felly mae hon yn sail ddilys yn y fan hon, y rhain sydd wedi eu rhestru? Nid ydynt yn cael eu gwyrdroi drwy werthu ar golled ar hyn o bryd?

Ms Poulter: No, I do not believe so. There may be an element of that.

Ms Poulter: Na, ni chredaf hynny. Efallai fod elfen o hynny.

[22] **Dafydd Wigley:** That is helpful.

[22] **Dafydd Wigley:** Mae hynny'n ddefnyddiol.

[23] **Ann Jones:** Ms Lloyd, you did refer to negotiating with the pharmaceutical industry and you did say that it takes—I think you said—the might of the Assembly. I was going to ask you about that but I think that you have acknowledged that there would be difficulties there, so how do you intend to build up in any way the expertise within the national health service to actually take on a successful and meaningful negotiation with pharmaceutical companies?

[23] **Ann Jones:** Ms Lloyd, cyfeiriasoch at negodi gyda'r diwydiant fferyllol gan ddweud ei bod hi'n cymryd—credaf ichi ddweud—nerth y Cynulliad. Yr oeddwn yn mynd i'ch holi am hynny ond credaf i chi gydnabod y byddai anawsterau yn y fan honno, felly sut yr ydych yn bwriadu datblygu mewn unrhyw fodd yr arbenigedd o fewn y gwasanaeth iechyd gwladol i gynnal negodiad llwyddiannus ac ystyrlon gyda chwmnïau fferyllol?

Ms Lloyd: Well, there is some expertise anyway in the all-Wales group that has been negotiating the secondary care drugs, so we can build on the experience that it has had, but all negotiation has to be undertaken with care because you only usually get one chance at it, and we would obviously build on the lessons that it has learned. It will have contacts with the drugs companies anyway, and their representatives. I think that we have to test this steadily and try to pick our targets very carefully, so that we are not wasting the chances that we do have. That, again, is part of the evaluation of the risk of undertaking

Ms Lloyd: Wel, mae rhywfaint o arbenigedd beth bynnag yn y grŵp Cymru gyfan a fu'n negodi'r cyffuriau gofal eilaidd, felly gallwn adeiladu ar y profiad a gafodd, ond rhaid cynnal yr holl negodi gyda gofal oherwydd un cyfle'n unig y cewch, a byddem yn amlwg yn adeiladu ar y gwersi y mae wedi eu dysgu. Bydd ganddo gysylltiadau â'r cwmnïau cyffuriau beth bynnag, a'u cynrychiolwyr. Credaf fod yn rhaid i ni brofi hyn yn raddol a cheisio dewis ein targedau'n ofalus iawn, fel nad ydym yn gwastraffu'r cyfleoedd sydd gennym. Mae hynny, unwaith eto, yn rhan o'r gwerthusiad o'r risg o negodi ymhellach

further negotiation with the pharmaceutical companies, or anybody else for that matter.

gyda'r cwmnïau fferyllol, neu gydag unrhyw un arall o ran hynny.

[24] **Dafydd Wigley:** May I now turn to issues of prescribing and medicines management? I refer to part 4 of the report, which describes a range of initiatives that could reduce expenditure on medicines in Wales. Part 4 of the report indicates that there may be significant savings made for the Assembly through better prescribing and better medicines management. The report also indicates that these are not new ideas. Why, then, has progress in securing these savings been rather slow?

[24] **Dafydd Wigley:** A gaf fi yn awr droi at faterion rhagnodi a rheoli meddyginiaethau? Cyfeiriaf at ran 4 yr adroddiad, sy'n disgrifio amrywiaeth o fentrau a allai leihau gwariant ar feddyginiaethau yng Nghymru. Mae rhan 4 yr adroddiad yn nodi y gallai'r Cynulliad wneud arbedion sylweddol drwy ragnodi gwell a rheoli meddyginiaethau'n well. Mae'r adroddiad hefyd yn nodi nad syniadau newydd yw'r rhain. Pam, felly, y bu'r cynnydd yn y gwaith o sicrhau'r arbedion hyn braidd yn araf?

Ms Lloyd: I do not think that we have been doing nothing; we have been making steady progress. There is a balance here—medicines management has been good practice for many years, and that is why you have seen the growth of formularies and the seeking of alternatives and generics whenever possible. The use of generics has grown quite considerably in the past five years, so that has been good. The establishment of things like the information centre on the efficacy of drugs and substitutions has been available in Wales for some time now. Also, there has been a growth over the past few years of these relationships and partnerships between secondary and primary care, where you look at the whole pathway of the patient's illness and disease and there is an agreement between the two partners about the right drug regime that is necessary for the patient. There was a tremendous amount of criticism from primary care, some three or four years ago, when some extremely expensive new drugs were being prescibed in the secondary care service which were really escalating the costs in primary care, where they did not have the negotiated basis of secondary care. So I think that there has been quite a change in the way in which people have started to look at drugs and their management. All the health authorities, and now the local health boards, will have pharmacy advisers. They have made quite a difference to the way in which GPs have been giving out drugs.

Ms Lloyd: Ni chredaf ein bod wedi bod yn gwneud dim; yr ydym wedi bod yn gwneud cynnydd graddol. Mae cydbwysedd yn y fan hon—mae rheoli meddyginiaethau wedi bod yn arfer da ers sawl blwyddyn, a dyna pam yr ydych wedi gweld twf cyffurlyfrau a'r arfer o chwilio am feddyginiaethau amgen a generig pryd bynnag y bo hynny'n bosibl. Mae'r defnydd o feddyginiaethau generig wedi tyfu'n eithaf sylweddol yn y pum mlynedd diwethaf, felly mae hynny wedi bod yn dda. Mae sefydlu pethau fel y ganolfan wybodaeth am effeithiolrwydd cyffuriau ac amnewidiadau wedi bod ar gael yng Nghymru ers cryn amser bellach. Yn ogystal, bu twf yn y blynyddoedd diwethaf yn y cysylltiadau a'r partneriaethau hyn rhwng gofal eilaidd a sylfaenol, lle'r ydych yn edrych ar lwybr salwch a chlefyd y claf yn gyflawn ac mae'r ddau bartner yn gytûn am y drefn gyffuriau gywir sydd ei hangen ar y claf. Cafwyd llawer iawn o feirniadaeth gan ofal sylfaenol, rhyw dair neu bedair blynedd yn ôl, pan yr oedd rhai cyffuriau newydd hynod o ddrud yn cael eu rhagnodi yn y gwasanaeth gofal eilaidd a oedd mewn gwirionedd yn cynyddu'r costau mewn gofal sylfaenol, lle nad oeddynt wedi negodi yn yr un modd â gofal eilaidd. Felly credaf fod cryn newid wedi bod yn y modd y mae pobl wedi dechrau edrych ar gyffuriau a'u rheolaeth. Bydd cynghorwyr fferyllfa gan yr holl awdurdodau iechyd, a bellach y byrddau iechyd lleol. Maent wedi gwneud tipyn o wahaniaeth i'r modd y mae meddygon teulu wedi bod yn dosbarthu cyffuriau.

However, there is still room for improvement. There is always room for

Fodd bynnag, mae lle i wella o hyd. Mae bob amser lle i wella. Dyna pam yr wyf yn

improvement. That is why I am very keen indeed to ensure that, on a more local basis, we can manage and performance manage the work that is done to try to drive down primary care dispensing values. We are also faced with the fact that costs are escalating in prescribing generally—not because people are not being careful and cautious, but because we are getting new drugs in the market that have never been available to us before and which are beneficial to patients. They are not cheap, but they are very beneficial and you only get the cost release at the end of the day. That might be four or five years down the track, when we prevent admission to hospital because of better drugs management in the community.

awyddus iawn yn wir i sicrhau y gallwn reoli a rheoli perfformiad y gwaith a wneir i geisio gostwng gwerthoedd dosbarthu gofal sylfaenol yn fwy lleol. Yr ydym hefyd yn wynebu'r ffaith bod costau yn cynyddu ym maes rhagnodi yn gyffredinol—nid oherwydd nad yw pobl yn ofalus ac yn bwyllog, ond oherwydd ein bod yn cael cyffuriau newydd yn y farchnad na fuont erioed ar gael i ni o'r blaen ac sy'n llesol i gleifion. Nid ydynt yn rhad, ond maent yn llesol iawn ac yr ydych ond yn cael y gost ryddhau yn y pen draw. Efallai y bydd hynny bedair neu bum mlynedd yn ddiweddarach, pan yr ydym yn osgoi cyfnod mewn ysbyty oherwydd bod cyffuriau'n cael eu rheoli'n well yn y gymuned.

So it is not fair, I think, to say that nothing has been done, but we need to make sure that it is universal. I think that that is where my concerns are—that we are not being smart enough at the moment to ensure that everyone is following the best practice and that they are tested against that, and that we do not at all times look for generic substitution for really good medicines management.

Felly, ni chredaf ei bod yn deg dweud nad oes unrhyw beth wedi ei wneud, ond mae angen i ni sicrhau ei fod yn digwydd ym mhob man. Credaf mai dyna ble mae fy mhryderon—nad ydym yn ddigon clyfar ar hyn o bryd i sicrhau bod pawb yn dilyn yr arferion gorau a'u bod yn cael eu profi yn erbyn hynny, ac nad ydym bob amser yn chwilio am amnewidiad generig er mwyn cael rheolaeth dda iawn o feddyginiaethau.

[25] **Dafydd Wigley:** Eleanor, did you want to come in on this?

[25] **Dafydd Wigley:** Eleanor, a ydych am ddweud rhywbeth am hyn?

[26] **Eleanor Burnham:** On this point, are you happy that GPs are fully aware of all the implications of drug prescribing? I say this without being patronising. It seems to me that pharmacists have far more knowledge and perhaps we are not using them sufficiently, particularly when it comes to multiple prescribing to older people, to use the technical term.

[26] **Eleanor Burnham:** Ar y pwynt hwn, a ydych yn hapus bod meddygon teulu yn gwbl ymwybodol o holl oblygiadau rhagnodi cyffuriau? Dywedaf hyn heb fod yn nawddoglyd. Mae'n ymddangos i mi fod gan fferyllwyr lawer mwy o wybodaeth ac efallai nad ydym yn gwneud defnydd digonol ohonynt, yn enwedig pan ddaw hi i ragnodi mwy nag un cyffur i bobl hŷn, i ddefnyddio'r term technegol.

Ms Lloyd: I think that pharmacists are rather an undervalued species. I think that, with better partnership with pharmacists—they are the experts in drugs after all. It is their profession to understand drug interactions, and I think that far more can be made of the pharmaceutical intelligence that is available within Wales. Hopefully, with the focus now being placed on primary healthcare teams that involve pharmacists fully, we might start to see some changed behaviour. Pharmacists have a great deal to offer, particularly where

Ms Lloyd: Credaf fod fferyllwyr yn bobl sy'n cael eu tanbrisio. Credaf, gyda gwell partneriaeth gyda fferyllwyr—hwy yw'r arbenigwyr ar gyffuriau wedi'r cyfan. Eu proffesiwn yw deall adweithiau rhwng cyffuriau, a chredaf y gellid gwneud llawer mwy â'r deallusrwydd fferyllol sydd ar gael yng Nghymru. Y gobaith yw, gyda'r pwyslais bellach ar dimau gofal iechyd sylfaenol sy'n cynnwys fferyllwyr yn llawn, efallai y dechreuwn weld rhywfaint o newid mewn ymddygiad. Mae gan fferyllwyr lawer

you are dealing with a complex illness which requires a cocktail of medications. They can also give advice on substitution. We need to encourage all our GPs. Many of them work hand in glove with their pharmacists, but we need to ensure that that good practice is spread throughout Wales.

i'w gynnig, yn enwedig lle'r ydych yn delio ag afiechydon cymhleth sydd angen cyfuniad o feddyginiaethau. Gallant hefyd roi cyngor ar amnewid. Mae angen i ni annog ein meddygon teulu i gyd. Mae llawer ohonynt yn gweithio law yn llaw â'u fferyllwyr, ond mae angen i ni sicrhau y lledaenir arferion da ledled Cymru.

[27] **Dafydd Wigley:** I know that Janet wants to follow on with some questions relating to pharmacists, but before that may I ask whether there is anything further that the Assembly can do to overcome some of the barriers to getting the savings that you say are there? Some progress has been made towards them; there is more that can be made perhaps. Is there anything that the Assembly can do?

[27] **Dafydd Wigley:** Gwn fod Janet am barhau â rhai cwestiynau yn ymwneud â fferyllwyr, ond cyn hynny, a gaf fi ofyn a oes rhywbeth arall y gall y Cynulliad ei wneud i oresgyn rhai o'r rhwystrau rhag sicrhau'r yr arbedion y dywedwch sydd yna? Mae rhywfaint o gynnydd wedi ei wneud tuag atynt; efallai fod mwy y gellir ei wneud. A oes rhywbeth y gall y Cynulliad ei wneud?

Ms Lloyd: Oh, yes. I think that, through the performance management system that we will have up and running from 1 April, now that it has finally been piloted, and which we will run with the local health boards, we can test the advances that are being made in the localities in terms of better medicines management, the control of prescribing costs and the roll-out of new products and at the same time be running these pilots to try to ensure that the procurement is as slick, efficient and cost-effective as possible. I think that that is the best way to do it, as part of the management of a whole community's health and to keep a really quite strict eye on it, because we have to be able to ensure that the prescribing budgets are used for advancement and not as a consequence of not managing value for money really well.

Ms Lloyd: O, oes. Credaf, drwy'r system rheoli perfformiad y bydd gennym ar waith o 1 Ebrill, gan ei bod bellach wedi bod drwy gynllun peilot o'r diwedd, ac y byddwn yn ei gweithredu gyda'r byrddau iechyd lleol, y gallwn brofi'r cynnydd sy'n cael ei wneud yn yr ardaloedd lleol o ran rheolaeth well o feddyginiaethau, rheoli costau rhagnodi a chyflwyno cynhyrchion newydd ac ar yr un pryd cynnal y cynlluniau peilot hyn i geisio sicrhau bod caffael mor hwylus, effeithlon a chost effeithiol â phosibl. Credaf mai dyna yw'r ffordd orau o'i wneud, fel rhan o'r gwaith o reoli iechyd cymuned gyfan ac i gadw llygad barcud arno, oherwydd rhaid i ni allu sicrhau bod y cyllidebau rhagnodi yn cael eu defnyddio er cynnydd ac nid o ganlyniad i beidio â rheoli gwerth am arian yn dda iawn.

[28] **Dafydd Wigley:** Indeed. Janet?

[28] **Dafydd Wigley:** Yn wir. Janet?

[29] **Janet Davies:** Could I first of all get a definition clear in my mind? We talk about community pharmacists. By 'community pharmacists' do you include the supermarket pharmacies or are you thinking purely of the small individual pharmacy shops?

[29] **Janet Davies:** A allaf yn gyntaf gael diffiniad yn glir yn fy meddwl? Siaradwn am fferyllwyr cymuned. Wrth sôn am 'fferyllwyr cymuned' a ydych yn cynnwys y fferyllfeydd mewn archfarchnadoedd neu a ydych yn cyfeirio at siopau fferyllfa unigol bach yn unig?

Ms Poulter: Generally, you regard community pharmacists as pharmacists who work in the community and who dispense GP prescriptions, so that would include supermarkets. All pharmacists have the same basic qualification, they are registered with

Ms Poulter: Yn gyffredinol, yr ydych yn ystyried fferyllwyr cymuned fel fferyllwyr sy'n gweithio yn y gymuned ac sy'n dosbarthu presgripsiynau meddygon teulu, felly byddai hynny'n cynnwys archfarchnadoedd. Mae gan bob fferyllydd yr

the Royal Pharmaceutical Society, and will provide pharmaceutical services to the same standard.

un cymwysterau sylfaenol, maent wedi eu cofrestru gyda'r Gymdeithas Fferyllol Frenhinol, a byddant yn darparu gwasanaethau fferyllol i'r un safon.

[30] **Janet Davies:** Thank you for that, because I think that most of us have had letters concerning issues relating to that. I just wanted to clarify it in my own mind before I went any further. I turn to paragraph 4.7, which describes pharmacists' concerns that moving from a reimbursement system could threaten the viability of their services. What, Ms Lloyd, is your assessment of the concerns of community pharmacists regarding impaired services as a result of changes in procurement?

[30] **Janet Davies:** Diolch am hynny, oherwydd credaf fod y mwyafrif ohonom wedi cael llythyrau am faterion yn gysylltiedig â hynny. Yr oeddwn am ei wneud yn glir yn fy meddwl fy hun cyn i mi fynd dim pellach. Trof at baragraff 4.7, sy'n disgrifio pryderon fferyllwyr y gallai symud o system ad-dalu fygwth dichonadwyedd eu gwasanaethau. Beth, Ms Lloyd, yw eich asesiad o bryderon fferyllwyr cymuned ynglŷn â gwasanaethau diffygiol o ganlyniad i newidiadau mewn caffael?

Ms Lloyd: I will ask Carolyn to answer that, if I may, because she understands the intricacies of the discounts and the profits margins and so on that are run by the community pharmacists.

Ms Lloyd: Gofynnaf i Carolyn ateb hynny, os caf fi, oherwydd mae hi'n deall cymhlethdodau'r gostyngiadau a'r meintiau elw ac ati sy'n cael eu cynnal gan y fferyllwyr cymuned.

Ms Poulter: As you alluded to, this report has similar connotations to the Office of Fair Trading report, 'The Control of Entry Regulations and Retail Pharmacy Services in the UK', in that changes could affect pharmacists' profit margins. We do not have the information as to the viability of certain pharmacies, but, certainly, some pharmacies, perhaps in rural areas, will have smaller profit margins than others. So, really, as Ms Lloyd said earlier, the point to note is that we assess the risks of making any changes to procurement. We will assess them very carefully, and work with stakeholders when working up pilot schemes.

Ms Poulter: Fel y crybwyllasoch, mae gan yr adroddiad hwn oblygiadau tebyg i adroddiad y Swyddfa Masnachu Teg, 'The Control of Entry Regulations and Retail Pharmacy Services in the UK', i'r perwyl y gallai newidiadau effeithio ar feintiau elw fferyllwyr. Nid oes gennym y wybodaeth ynglŷn â dichonadwyedd fferyllfeydd penodol, ond, yn sicr, bydd gan rai fferyllfeydd, efallai mewn ardaloedd gwledig, feintiau elw llai nag eraill. Felly, mewn gwirionedd, fel y dywedodd Ms Lloyd yn gynharach, y pwynt i'w nodi yw ein bod yn asesu'r risgiau sy'n gysylltiedig â gwneud unrhyw newidiadau i gaffael. Byddwn yn eu hasesu'n ofalus iawn, ac yn gweithio gyda rhanddeiliaid tra'n gwella cynlluniau peilot.

[31] **Janet Davies:** Thank you. I think that my last question has been answered already to quite an extent, but you may wish to clarify it a bit further. There is the problem of the risk of centralised services impairing pharmacy services. You mentioned at one point having too many eggs in one basket. Is there anything that you would like to say to further that point?

[31] **Janet Davies:** Diolch. Credaf fod fy nghwestiwn olaf eisoes wedi cael ei ateb i raddau helaeth, ond efallai yr hoffech ei egluro ychydig ymhellach. Mae'r broblem o'r risg y gallai gwasanaethau wedi eu canoli amharu ar wasanaethau fferyllol. Soniasoch ar un adeg am gael gormod o wyau yn yr un fasged. A oes rhywbeth yr hoffech ei ddweud i ymhelaethu ar y pwynt hwnnw?

Ms Lloyd: Well, I think that I would just like to reiterate that, in making any change of this nature, the pilot schemes must evaluate the

Ms Lloyd: Wel, credaf fy mod ond am ailadrodd, o wneud unrhyw newid o'r math hwn, bod yn rhaid i'r cynlluniau peilot

risks really effectively. The last thing that anybody wishes to do is to destabilise a whole system, which will stop people being able to access the drug regimes that are required to keep them well and healthy. There is also the whole issue of dispensing GPs, particularly in rural areas, and the community pharmacists, particularly in rural areas, or where the communities rely very heavily on them. We must ensure that we weigh those risks very carefully indeed before we make any wholesale change, because it is really important that we maintain these services for people in these communities.

werthuso'r risgiau yn effeithiol iawn. Y peth diwethaf mae unrhyw un am ei wneud yw dadsefydlogi'r system gyfan, a fydd yn rhwystro pobl rhag gallu cael mynediad i'r cyffuriau angenrheidiol i'w cadw'n fyw ac yn iach. Mae hefyd y mater o feddygon teulu yn dosbarthu, yn enwedig mewn ardaloedd gwledig, a'r fferyllwyr cymuned, yn enwedig mewn ardaloedd gwledig, neu lle mae'r cymunedau'n dibynnu'n drwm iawn arnynt. Rhaid i ni sicrhau ein bod yn pwyso a mesur y risgiau hynny yn ofalus iawn yn wir cyn i ni wneud unrhyw newid mawr, oherwydd mae'n bwysig iawn ein bod yn cynnal y gwasanaethau hyn ar gyfer pobl yn y cymunedau hyn.

[32] **Dafydd Wigley:** Have you finished, Janet?

[32] **Dafydd Wigley:** A ydych wedi gorffen, Janet?

[33] **Janet Davies:** I was just going to say that I am certainly very well aware that, quite often, it seems as though the service is quite strained on the ground when you have to actually wait for the drugs until the afternoon or the following day. Therefore, I think that it is something that we must be very aware of.

[33] **Janet Davies:** Yr oeddwn ar fin dweud fy mod yn sicr yn ymwybodol iawn, yn aml iawn, ei bod hi'n ymddangos bod y gwasanaeth dan dipyn o straen ar lawr gwlad pan fo'n rhaid i chi aros am y cyffuriau tan y prynhawn neu drannoeth. Felly, credaf ei fod yn rhywbeth y mae'n rhaid i ni fod yn ymwybodol iawn ohono.

[34] **Dafydd Wigley:** It is a balance, is it not? Alison, do you want to come in on this?

[34] **Dafydd Wigley:** Onid cydbwysedd ydyw? Alison, a ydych am gyfrannu at hyn?

[35] **Alison Halford:** Yes, on a very quick point. First of all, I think that it is very useful that Janet has asked for a definition of community pharmacists. Surely, it covers and embraces everybody. What is a non-community pharmacist, may I ask?

[35] **Alison Halford:** Ydw, ar bwynt cyflym iawn. Yn gyntaf oll, credaf ei bod yn ddefnyddiol iawn bod Janet wedi gofyn am ddiffiniad o fferyllwyr cymuned. Yn ddiau, y mae'n cynnwys ac yn cwmpasu pawb. A gaf fi ofyn beth yw fferyllydd nad yw'n fferyllydd cymuned?

Ms Lloyd: A hospital one.

Ms Lloyd: Fferyllydd ysbyty.

[36] **Alison Halford:** Oh, it is a hospital one. Community to me means small chemists in rural areas and things like that. However, I am very pleased that you indicated in what you have just said that you are supporting what I consider to be a community pharmacist, which is possibly not a supermarket. My particular area depends on small pharmacists in little towns and villages and so on, so what you said was very comforting.

[36] **Alison Halford:** O, fferyllydd ysbyty ydyw. Mae cymuned i mi yn golygu fferyllfeydd bach mewn ardaloedd gwledig a phethau felly. Fodd bynnag, yr wyf yn falch i chi nodi yn yr hyn yr ydych newydd ei ddweud eich bod yn cefnogi yr hyn yr ystyriaf yn fferyllydd cymuned, nad yw'n archfarchnad o bosibl. Mae fy ardal benodol i yn dibynnu ar fferyllfeydd bach mewn pentrefi a threfi bach ac ati, felly yr oedd yr hyn a ddywedasoch yn gysur mawr.

[37] **Dafydd Wigley:** Before we move on to

[37] **Dafydd Wigley:** Cyn i ni symud ymlaen

the GP aspect, which I think that Alun will take on, may I just ask whether you believe there is any scope for the essential small pharmacy scheme coming in as a safety net if there were some perceived loss of income from changes arising from this study?

at fater y meddyg teulu, a fydd dan ofal Alun yr wyf yn credu, a gaf fi ofyn a ydych yn credu bod unrhyw bosibilrwydd y gallai'r cynllun fferyllfa fach hanfodol fod yn rhwyd achub pe bai rhywfaint o golled incwm cydnabyddedig yn sgîl newidiadau yn deillio o'r astudiaeth hon?

Ms Lloyd: I think that that is something that we would have to consider very carefully. There are issues around the terms and conditions on which pharmacists are employed at the moment and the independent contractor nature of their status. I think that we just have to ensure that we take that into consideration—

Ms Lloyd: Credaf fod hynny yn rhywbeth y byddai'n rhaid i ni ei ystyried yn ofalus iawn. Mae materion ynghylch yr amodau a'r telerau sy'n sail i gyflogi fferyllwyr ar hyn o bryd a natur contractwr annibynnol eu statws. Credaf fod angen i ni ond sicrhau ein bod yn ystyried hynny—

[38] **Dafydd Wigley:** Am I not right in saying that we in the Assembly have powers to vary that scheme? If that is the case, that might be one way forward. Is that something that you would consider?

[38] **Dafydd Wigley:** Onid ydwyf yn gywir i ddweud bod gennym ni yn y Cynulliad bwerau i amrywio'r cynllun hwnnw? Os mai dyna'r achos, efallai fod hynny'n un ffordd ymlaen. A yw hynny'n rhywbeth y byddech yn ei ystyried?

Ms Lloyd: Yes.

Ms Lloyd: Ydyw.

[39] **Alun Cairns:** Ms Lloyd, I want to refer to paragraph 4.9, which sets out the concerns of dispensing GPs that moving from a reimbursement system could act as a disincentive to GPs taking up practice in rural areas. What is your assessment of that, and would you also couple that to letting us know whether there is a shortage of GPs in rural areas?

[39] **Alun Cairns:** Ms Lloyd, yr wyf am gyfeirio at baragraff 4.9, sy'n nodi pryderon meddygon teulu sy'n dosbarthu y gallai symud i ffwrdd o system ad-dalu fod yn rhwystr i feddygon teulu rhag cymryd practis mewn ardaloedd gwledig. Beth yw'ch asesiad o hynny, ac a fyddech hefyd yn cyplysu hynny â dweud wrthym a oes prinder meddygon teulu mewn ardaloedd gwledig?

Ms Lloyd: As you know, we have a shortage of GPs right across Wales, particularly in some of the Valleys communities and some of the rural areas. That is why a considerable amount of effort is going into increasing training and inducing people to come to Wales to take up practices. In terms of the dispensing general practitioners, these are largely prevalent in the rural areas and their terms and conditions are being considered slightly separately from the GP contract; they are not included yet as a particular issue in that GP contract that is being negotiated at the moment. They are being regarded as a separate case, which would be an addition to the GP contract, because it is recognised that there is vulnerability in making any radical changes around their status and our ability to be able to maintain those people within the

Ms Lloyd: Fel y gwyddoch, mae gennym brinder meddygon teulu ledled Cymru, yn enwedig yn rhai o gymunedau'r Cymoedd a rhai o'r ardaloedd gwledig. Dyna pam mae cryn dipyn o ymdrech yn cael ei roi i'r gwaith o gynyddu hyfforddiant ac annog pobl i ddod i Gymru i gymryd practis. O ran meddygon teulu sy'n dosbarthu, mae'r rhain, i raddau helaeth, yn gyffredin yn yr ardaloedd gwledig ac mae eu hamodau a'u telerau yn cael eu hystyried ychydig ar wahân i'r contract meddyg teulu; nid ydynt wedi eu cynnwys hyd yn hyn fel mater penodol yn y contract meddyg teulu hwnnw sy'n cael ei negodi ar hyn o bryd. Maent yn cael eu hystyried fel achos ar wahân, a fyddai'n ychwanegol i'r contract meddyg teulu, oherwydd cydnabyddir bod gwendid o wneud unrhyw newidiadau radical i'w statws a'n

rural communities. So, it is very important.

gallu ni i gynnal y bobl hynny yn y cymunedau gwledig. Felly, mae'n bwysig iawn.

[40] **Alun Cairns:** So, building on that—and in the response to Dafydd Wigley a little earlier where the essential small pharmacy scheme was highlighted, you recognised that there might be a need to look at that, certainly because of the difficulties for what we would usually call community pharmacies, particularly in rural areas—can you reassure the Committee by saying that a similar sort of scheme might well be explored in relation to the dispensing GPs because of the vulnerability of the rural areas particularly?

[40] **Alun Cairns:** Felly, gan adeiladu ar hynny—ac mewn ymateb i Dafydd Wigley ychydig yn gynharach lle amlygwyd y cynllun fferyllfa fach hanfodol, bu i chi gydnabod efallai fod angen edrych ar hwnnw, yn sicr oherwydd yr anawsterau ar gyfer yr hyn y byddem fel arfer yn eu galw'n fferyllfeydd cymuned, yn enwedig mewn ardaloedd gwledig—a allwch chi sicrhau'r Pwyllgor drwy ddweud y gellid ystyried cynllun tebyg ar gyfer meddygon teulu sy'n dosbarthu, oherwydd sefyllfa wan yr ardaloedd gwledig yn enwedig?

Ms Lloyd: The dispensing GPs are recognised as a special case within the GP negotiations that the NHS Confederation is undertaking on behalf of the four Governments at the moment. We await to see the sort of responses that we get between the general practitioner committee and confederation.

Ms Lloyd: Mae'r meddygon teulu sy'n dosbarthu yn cael eu cydnabod fel achos arbennig yn y negodiadau meddygon teulu y mae'r Conffederasiwn GIG yn eu cynnal ar ran y bedair Llywodraeth ar hyn o bryd. Yr ydym yn aros i weld pa fath o ymatebion a gawn rhwng y pwyllgor meddygon teulu a'r conffederasiwn.

[41] **Alun Cairns:** I am looking for a reassurance that, if a scheme might be considered for the community pharmacies in rural areas, the dispensing GPs will not be forgotten.

[41] **Alun Cairns:** Yr wyf yn chwilio am sicrwydd na fydd y meddygon teulu sy'n dosbarthu yn cael eu hanghofio pe bai cynllun yn cael ei ystyried o bosibl ar gyfer y fferyllfeydd cymuned mewn ardaloedd gwledig.

Ms Lloyd: They certainly will not be forgotten because we have already highlighted to the confederation and the GPC that this is an issue for us.

Ms Lloyd: Yn bendant ni fyddant yn cael eu hanghofio oherwydd yr ydym eisoes wedi amlygu i'r conffederasiwn a'r pwyllgor meddygon teulu bod hwn yn fater i ni.

[42] **Alun Cairns:** Paragraph 4.13 sets out pharmaceutical industry concerns. Naturally, it would have concerns because, if the NHS wants to make some cost savings, they must come from somewhere. I suspect that the industry is likely to bear the brunt of that cost saving. What is your view on the potential impact on the pharmaceutical industry of the changes in procurement?

[42] **Alun Cairns:** Y mae paragraff 4.13 yn nodi pryderon y diwydiant fferyllol. Yn naturiol, byddai ganddo bryderon oherwydd, os yw'r GIG am wneud rhai arbedion cost, rhaid iddynt ddod o rywle. Yr wyf yn amau mai'r diwydiant sy'n debygol o ddwyn baich yr arbed cost hwnnw. Beth yw'ch barn ar effaith bosibl y newidiadau mewn caffael ar y diwydiant fferyllol?

Ms Lloyd: I cannot tell you what they would be at the moment, obviously. Their profit margins might reduce. The Auditor General has helpfully outlined what the problems could be. Particularly for us, a reduction in research and development would have to be

Ms Lloyd: Ni allaf ddweud wrthych beth fyddent ar hyn o bryd, mae'n amlwg. Gallai eu meintiau elw leihau. Mae'r Archwilydd Cyffredinol wedi amlinellu'n ddefnyddiol y problemau a allai godi. Yn enwedig ar ein cyfer ni, byddai'n rhaid pwyso a mesur

weighed very carefully because that is very important to the service as a whole. Whether or not, if Wales went on its own, they would regard it as having much effect at all on their profit margin is something that we would have to consider very carefully. However, again, we would have to take the advice in this report as part of the risk in looking at changing any way in which we procure.

lleihad mewn ymchwil a datblygu yn ofalus iawn oherwydd mae hynny'n bwysig iawn i'r gwasanaeth yn ei gyfanrwydd. Pe bai Cymru'n mynd ar ei phen ei hun, mae a fyddent yn ystyried ei fod yn cael llawer o effaith ar eu maint elw ai peidio yn rhywbeth y byddai'n rhaid i ni ei ystyried yn ofalus iawn. Fodd bynnag, unwaith eto, byddai'n rhaid i ni gymryd y cyngor yn yr adroddiad hwn fel rhan o'r risg o edrych ar newid unrhyw fodd yr ydym yn caffael.

[43] **Alun Cairns:** Thank you. Cadeirydd, I have one final comment, if that is okay. You mentioned the impact of research and development, but we cannot forget that research and development is a global market and I would imagine that the procurement of pharmaceuticals in Wales is a very small part of that.

[43] **Alun Cairns:** Diolch. Gadeirydd, mae gennyf un sylw olaf, os yw hynny'n iawn. Soniasoch am effaith ymchwil a datblygu, ond ni allwn anghofio bod ymchwil a datblygu yn farchnad fyd-eang a byddwn yn dychmygu bod caffael meddyginiaethau yng Nghymru yn rhan fach iawn ohoni.

Ms Lloyd: Yes, I note that.

Ms Lloyd: Ydyw, yr wyf yn nodi hynny.

[44] **Dafydd Wigley:** Yes, indeed. In terms of profitability, I think that a return on capital of 21 per cent is what is regarded as a norm, and it is only when a company exceeds its target profit by 40 per cent that any question of repaying comes in. So, there is a reasonable level of profitability there, is there not?

[44] **Dafydd Wigley:** Ydyw, yn wir. O ran proffidioldeb, credaf mai elw ar gyfalaf o 21 y cant yw'r hyn a ystyrir yn arferol, a dim ond pan fo cwmni yn mynd y tu hwnt i'w elw darged gan 40 y cant y mae unrhyw gwestiwn o ad-dalu'n codi. Felly, mae lefel resymol o broffidioldeb yno, onid oes?

Ms Lloyd: Yes.

Ms Lloyd: Oes.

[45] **Dafydd Wigley:** In that context, if we were to go down this road in Wales, clearly the implications are not too serious, as has been suggested, in terms of research and development, unless our changes in Wales lead to similar changes elsewhere. May I ask you, are you coming under any pressure centrally, from London, to avoid going down a road such as this because of the knock-on effect?

[45] **Dafydd Wigley:** Yn y cyd-destun hwnnw, os byddem yn dilyn y ffordd hon yng Nghymru, mae'n amlwg nad yw'r goblygiadau yn rhy ddifrifol, fel sydd wedi ei awgrymu, o ran ymchwil a datblygu, oni bai fod ein newidiadau yng Nghymru yn arwain at newidiadau tebyg yn rhywle arall. A gaf fi ofyn i chi, a ydych dan unrhyw bwysau yn ganolog, o Lundain, i osgoi dilyn trywydd tebyg oherwydd y sgîl-effaith?

Ms Lloyd: No, not at the moment. There is the Department of Health's review into generics going on at the moment, of which we are a part. This is not an issue on which I, personally, or any of my staff have been put under pressure. This is a genuine report from the Auditor General, who scrutinises both of us, and we are required to take forward the suggestions that he has made, bearing in mind the risks, which he has rightly pointed

Ms Lloyd: Na, ddim ar hyn o bryd. Mae adolygiad yr Adran Iechyd ar feddyginiaethau generig yn cael ei gynnal ar hyn o bryd, ac yr ydym yn rhan ohono. Nid yw hwn yn fater yr wyf i, yn bersonol, nac unrhyw aelod o fy staff wedi cael ein rhoi o dan bwysau yn ei gylch. Mae hwn yn adroddiad dilys gan yr Archwilydd Cyffredinol, sy'n archwilio'r ddau ohonom, ac mae'n ofynnol i ni ddatblygu'r

out, which might surround it. I am sure that our English colleagues would like to see how we get on about it. However, there is no pressure.

[46] **Dafydd Wigley:** Yes, indeed. That is very positive.

[47] **Eleanor Burnham:** May I come in on this?

[48] **Dafydd Wigley:** Very briefly, Eleanor.

[49] **Eleanor Burnham:** Is there any merit now in looking at reducing these huge prescriptive costs by perhaps piloting complementary medicine in the areas where they might be efficacious?

[50] **Dafydd Wigley:** Frankly, I think that that goes beyond this report.

[51] **Jocelyn Davies:** I think that the Member should declare an interest, because she has been an aromatherapist.

[52] **Eleanor Burnham:** Yes, sorry. I am a qualified aromatherapist.

[53] **Dafydd Wigley:** We will take that question as one that stands as a consideration. Janice?

[54] **Janice Gregory:** Thank you, Chair. Paragraph 4.19 says that Wales is slightly behind England and Scotland in terms of generic prescribing. Why is this, Ann?

Ms Lloyd: May Carolyn answer this? She has done some of the research into it.

[55] **Janice Gregory:** She certainly can.

Ms Poulter: Well, I am not sure that we do fully understand why. There are actually variations within Wales as to the generic prescribing rates. I believe that some parts of Wales are at a rate of about 62 per cent while others are at 76 per cent. I think that the important thing to remember is that we have made considerable progress in this area,

awgrymiadau mae ef wedi eu gwneud, gan gofio'r risgiau, y mae ef yn gywir wedi eu nodi, a allai fod yn gysylltiedig â hwy. Yr wyf yn siŵr y byddai ein cydweithwyr yn Lloegr yn hoffi gweld sut gynnydd y gwnawn yn ei gylch. Fodd bynnag, nid oes pwysau.

[46] **Dafydd Wigley:** Byddent, yn wir. Mae hynny'n gadarnhaol iawn.

[47] **Eleanor Burnham:** A gaf fi ddod i mewn ar hyn?

[48] **Dafydd Wigley:** Yn fyr iawn, Eleanor.

[49] **Eleanor Burnham:** A oes unrhyw werth yn awr i edrych ar leihau'r costau rhagnodi enfawr hyn drwy efallai roi prawf ar feddygaeth gyflenwol yn y meysydd lle gallai fod yn effeithiol?

[50] **Dafydd Wigley:** A bod yn onest, credaf fod hynny'n mynd y tu hwnt i'r adroddiad hwn.

[51] **Jocelyn Davies:** Credaf y dylai'r Aelod ddatgan buddiant, oherwydd yr oedd hi'n aromatherapydd.

[52] **Eleanor Burnham:** Dylwn, mae'n ddrwg gennyf. Yr wyf yn aromatherapydd cymwys.

[53] **Dafydd Wigley:** Cymerwn y cwestiwn hwnnw fel mater i'w ystyried. Janice?

[54] **Janice Gregory:** Diolch, Gadeirydd. Dywed paragraff 4.19 fod Cymru ychydig ar ei hôl hi o'i chymharu â Lloegr a'r Alban o ran rhagnodi generig. Pam felly, Ann?

Ms Lloyd: A all Carolyn ateb hwn? Mae hi wedi gwneud peth o'r ymchwil iddo.

[55] **Janice Gregory:** Wrth gwrs y gall.

Ms Poulter: Wel, nid wyf yn siŵr ein bod yn deall pam yn llawn. Mewn gwirionedd, mae'r cyfraddau rhagnodi generig yn amrywio o fewn Cymru. Credaf fod gan rai rhannau o Gymru gyfradd o tua 62 y cant tra bod gan eraill gyfraddau o 76 y cant. Credaf mai'r peth pwysig i'w gofio yw ein bod wedi gwneud cynnydd sylweddol yn y maes hwn,

increasing from 40 per cent to almost 70 per cent in the last 10 years. We do have a significant number of dispensing doctors in Wales so that could be an issue, but I have not examined the evidence for that.

yn cynyddu o 40 y cant i bron i 70 y cant yn y 10 mlynedd diwethaf. Mae gennym nifer sylweddol o feddygon sy'n dosbarthu yng Nghymru felly gallai hynny fod yn berthnasol, ond nid wyf wedi astudio'r dystiolaeth dros hynny.

The all-Wales medicines strategy group will be monitoring this—it has developed a set of high-level prescribing indicators, and it has actually started looking at generic prescribing rates across Wales. It will start looking at the differences within Wales. It is also to benchmark—it is going to start benchmarking with north-east England, which has a similar population to Wales, and look at why there may be differences between, say, England and Wales and look at solutions.

Bydd grŵp strategaeth meddyginiaethau Cymru gyfan yn monitro hyn—mae wedi datblygu cyfres o ddangosyddion rhagnodi lefel-uchel, ac mewn gwirionedd mae wedi dechrau edrych ar gyfraddau rhagnodi generig ledled Cymru. Bydd yn dechrau edrych ar y gwahaniaethau o fewn Cymru. Bydd hefyd yn meincnodi—mae'n mynd i ddechrau meincnodi gyda gogledd-ddwyrain Lloegr, sydd â phoblogaeth debyg i Gymru, ac edrych ar pam efallai fod gwahaniaethau rhwng, er enghraifft, Cymru a Lloegr ac ystyried atebion.

[56] **Janice Gregory:** You have partly answered my supplementary question, which was could Wales overtake England, but you obviously have to find out why it is that we are behind England and Scotland before you can start talking about overtaking them.

[56] **Janice Gregory:** Yr ydych wedi ateb fy nghwestiwn atodol yn rhannol, sef a allai Cymru fynd heibio i Loegr, ond mae'n amlwg bod yn rhaid i chi ganfod pam yr ydym y tu ôl i Loegr a'r Alban cyn y gallwch ddechrau sôn am fynd heibio iddynt.

[57] **Dafydd Wigley:** Before you leave that, am I right in saying that the northern region has in fact some 68 or 69 per cent of generic prescribing compared to 60 per cent in Wales? There is a 9 per cent, almost a 10 per cent, difference.

[57] **Dafydd Wigley:** Cyn i chi adael hynny, a ydwyf yn iawn i ddweud bod gan ranbarth gogledd Lloegr mewn gwirionedd gyfradd ragnodi generig o ryw 68 neu 69 y cant o gymharu â 60 y cant yng Nghymru? Mae hynny'n wahaniaeth o 9 y cant, bron i 10 y cant.

Ms Poulter: I thought that the Welsh level was higher than that, actually.

Ms Poulter: Yr oeddwn yn meddwl fod lefel Cymru yn uwch na hynny, a dweud y gwir.

[58] **Dafydd Wigley:** They are the Audit Commission figures that have been presented to us. It underlines the point that you are making and I think that it adds to the validity of seeing how we can close the gap.

[58] **Dafydd Wigley:** Dyna ffigurau'r Comisiwn Archwilio sydd wedi eu cyflwyno i ni. Mae'n tanlinellu'r pwynt yr ydych yn ei wneud a chredaf ei fod yn ychwanegu at ddilysrwydd gweld sut gallwn gau'r bwlch.

Ms Poulter: Absolutely.

Ms Poulter: Yn bendant.

[59] **Dafydd Wigley:** Sorry, Janice.

[59] **Dafydd Wigley:** Mae'n ddrwg gennyf, Janice.

[60] **Janice Gregory:** Obviously, the work is currently being undertaken, so I do not think that we can expand any further on that until the conclusions as to why are determined.

[60] **Janice Gregory:** Yn amlwg, mae'r gwaith yn cael ei gynnal ar hyn o bryd, felly ni chredaf y gallwn ehangu ymhellach ar hynny nes pennu'r casgliadau ynglŷn â pham y digwydd hynny.

[61] **Dafydd Wigley:** Alun, did you want to come in on that before Janice moves on to the next question?

[61] **Dafydd Wigley:** Alun, a oeddech am ddod i mewn ar hynny cyn i Janice symud ymlaen at y cwestiwn nesaf?

[62] **Alun Cairns:** Yes. I am concerned about an inconsistency that I have picked up from Ms Lloyd, if that is okay, Cadeirydd. Ms Lloyd, you mentioned earlier that there were some great developments at local levels in terms of negotiating—when we were pursuing questions about where the expertise lies within the local health boards to gain more generic prescriptions from GPs. If there is progress, I think that that is very good, and we need to welcome it. However, when we look at the figures for England and Wales—75 per cent in England and Scotland compared to 79 per cent in Wales—I hope that we are not being complacent.

[62] **Alun Cairns:** Oeddwn. Yr wyf yn pryderu am anghysondeb gan Ms Lloyd yr wyf wedi sylwi arno, os yw hynny'n iawn, Gadeirydd. Ms Lloyd, soniasoch yn gynharach fod rhai datblygiadau gwych yn lleol o ran negodi—pan oeddem yn holi cwestiynau ynglŷn â ble mae'r arbenigedd yn y byrddau iechyd lleol i sicrhau mwy o bresgripsiynau generig gan feddygon teulu. Os oes cynnydd, credaf fod hynny'n dda iawn, a dylem ei groesawu. Fodd bynnag, pan edrychwn ar y ffigurau ar gyfer Cymru a Lloegr—75 y cant yn Lloegr a'r Alban o gymharu â 79 y cant yng Nghymru—yr wyf yn gobeithio nad ydym yn bod yn hunanfodlon.

Ms Lloyd: No, we are not, and I do not think that I am being inconsistent either. There has been steady progress, and—

Ms Lloyd: Na, nac ydym, ac ni chredaf fy mod yn bod yn anghyson ychwaith. Bu cynnydd graddol, ac—

[63] **Alun Cairns:** But we are still not at the English level, though?

[63] **Alun Cairns:** Ond, er hynny, nid ydym ar lefel Lloegr o hyd?

Ms Lloyd: We are still not at the English level, but we are getting near to the English level, and some of the areas are at that comparable level.

Ms Lloyd: Nid ydym ar yr un lefel â Lloegr o hyd ond yr ydym yn agosáu at lefel Lloegr, ac mae rhai o'r ardaloedd ar y lefel gyffelyb honno.

[64] **Dafydd Wigley:** I think that the progress to which you refer probably refers to the difference between the figures that Carolyn had and mine. My figures were for 1998-99. There has been progress since then. So it is a matter of maintaining that.

[64] **Dafydd Wigley:** Credaf fod y cynnydd y cyfeiriwch ato yn ôl pob tebyg yn cyfeirio at y gwahaniaeth rhwng y ffigurau a oedd gan Caroline a'n rhai i. Yr oedd fy ffigurau i ar gyfer 1998-99. Bu cynnydd ers hynny. Felly mater o gynnal hwnnw ydyw.

[65] **Janice Gregory:** Paragraph 4.25—we are leaping around the paragraphs now—recommends that

'the Assembly's NHS Directorate should review the continued justification for GPs prescribing medicine that the *British National Formulary* indicates are of limited clinical value.'

What justification is there for a GP to prescribe medicines that are of limited clinical value? I hope that I am on the right

[65] **Janice Gregory:** Mae paragraff 4.25—yr ydym yn neidio o amgylch y paragraffau bellach—yn argymell

'y dylai Cyfarwyddiaeth GIG y Cynulliad adolygu a ellir parhau i gyfiawnhau bod meddygon y teulu yn rhagnodi meddyginiaethau sydd o werth clinigol cyfyngedig yn ôl *British National Formulary*.'

Pa gyfiawnhad sydd dros feddyg teulu yn rhagnodi meddyginiaethau sydd â gwerth clinigol cyfyngedig? Gobeithio fy mod ar y

track here, but, surely, when we ask patients to accept generic medicines, we would hasten to find out whether they were of limited clinical value, when it is quite difficult to get patients to accept cheaper alternatives?

trywydd cywir yn y fan hon, ond, nid oes bosibl, pan ofynnwn i gleifion dderbyn meddyginiaethau generig, y byddem yn prysuro i ganfod a oeddynt â gwerth clinigol cyfyngedig, pan fo'n eithaf anodd cael cleifion i dderbyn amnewidiadau rhatach?

Ms Lloyd: Could I deal with that latter point first, please? Just to clarify, generic drugs are not equivalent to drugs of limited clinical value. They are not the same thing at all. A generic is just a cheaper substitution—

Ms Lloyd: A allaf ddelio â'r pwynt diwethaf yn gyntaf, os gwelwch yn dda? I egluro, nid yw cyffuriau generig yn gyfwerth â chyffuriau sydd â gwerth clinigol cyfyngedig. Nid ydynt yr un peth o gwbl. Amnewidiad rhatach yn unig yw meddyginiaeth enerig—

[66] **Janice Gregory:** Panadol for paracetamol?

[66] **Janice Gregory:** Panadol ar gyfer paracetamol?

Ms Lloyd: Something like that, yes.

Ms Lloyd: Rhywbeth felly, ie.

It will allow—as long as it is therapeutically the same—when drugs come off licence, that they can be manufactured by a whole variety of people. It is the licence that triggers whether something is generic or not. There are an awful lot of drugs for which there is no generic substitution either because, therapeutically, they are not equivalent, or because they are still on licence. Sorry, I meant to say patent, not licence.

Bydd yn caniatáu—cyn belled â'i fod yr un fath yn therapiwtig—pan fo trwydded cyffuriau yn dod i ben, y gallant gael eu cynhyrchu gan amrywiaeth eang o bobl. Y drwydded sy'n pennu a yw rhywbeth yn enerig ai peidio. Mae llawer iawn o gyffuriau nad oes amnewidiad generig ar eu cyfer oherwydd, yn therapiwtig, nid ydynt yn gyfwerth, neu oherwydd eu bod ar drwydded o hyd. Mae'n ddrwg gennyf, yr oeddwn yn golygu dweud patent, nid trwydded.

What is the justification for prescribing something of limited benefit? Well, to be honest, I cannot justify that at all. I think that that is the sort of issue that we have to take up with our general practice colleagues. The last time that we had what was called a blacklist—I cannot remember how many years ago that was, it was about 10 or so. About 10 years ago, we had a blacklist throughout the UK on just this sort of issue. We found to our horror that, instead of people stopping prescribing, generally, against this blacklist, there were substitutions for far more expensive items. I do not think that we quite evaluated the risk of having a blacklist at that time. However, basically, if patients go to their doctors, they want good advice and they want the right clinical regime. Although some people will be convinced that a drug, any drug, will make them much better, nevertheless, that has to be a point of discussion between the GP and his or her patient, because there is no point. Although the drugs that fall into this

Beth yw'r cyfiawnhad dros ragnodi rhywbeth sydd â budd cyfyngedig? Wel, i fod yn onest, ni allaf gyfiawnhau hynny o gwbl. Credaf mai dyna'r math o fater y mae'n rhaid i ni ei drafod â'n cydweithwyr ym maes meddygaeth deuluol. Y tro diwethaf yr oedd gennym yr hyn a alwyd yn rhestr waharddedig—ni allaf gofio faint o flynyddoedd yn ôl oedd hynny, tua 10 neu rywbeth tebyg. Tua 10 mlynedd yn ôl, yr oedd gennym restr waharddedig ledled y DU ar y math hwn o fater yn union. Yn hytrach na phobl yn rhoi'r gorau i ragnodi, yn gyffredinol, yn unol â'r rhestr waharddedig hon, bu i ni ganfod, er mawr arswyd i ni, amnewidiadau am eitemau llawer drutach. Ni chredaf i ni werthuso'n iawn y risg o gael rhestr waharddedig bryd hynny. Fodd bynnag, yn y bôn, os yw cleifion yn mynd at eu meddygon, maent eisiau cyngor da ac maent eisiau'r drefn glinigol gywir. Er y bydd rhai pobl wedi'u hargyhoeddi y bydd cyffur, unrhyw gyffur, yn gwneud iddynt deimlo yn llawer gwell, serch hynny, rhaid i

definition are, apparently, relatively cheap, nevertheless, there has to be better discussion about what can improve the health of individuals when they go to see their primary care practitioner.

hynny fod yn destun trafod rhwng y meddyg teulu a'i glaf neu a'i chlaf, oherwydd nad oes diben. Er bod y cyffuriau sy'n perthyn i'r diffiniad hwn, mae'n debyg, yn gymharol rhad, serch hynny, rhaid bod trafodaeth well am beth all wella iechyd unigolion pan fônt yn mynd i weld eu hymarferydd gofal sylfaenol.

[67] **Janice Gregory:** So, in your opinion, do you think that these drugs are cost-effective? That is my supplementary question.

[67] **Janice Gregory:** Felly, yn eich barn chi, a gredwch fod y cyffuriau hyn yn gost effeithiol? Dyna fy nghwestiwn atodol.

Ms Lloyd: I do not know whether I can answer that question. I think that it might be argued that, if patients remain happy and feel that they are getting better, it is a matter of clinical judgment for their general practitioner. If it means that they have just a small clinical improvement, and it is the clinical judgment of the GP that it is a good investment for the person concerned, then that is down to his or her clinical judgment. That does not mean that the clinical judgment cannot be tested to ensure that it is soundly based.

Ms Lloyd: Ni wn a allaf ateb y cwestiwn hwnnw. Credaf y gellid dadlau, os yw cleifion yn parhau i fod yn hapus ac yn teimlo eu bod yn gwella, ei fod yn fater o farn glinigol eu meddyg teulu. Os yw'n golygu eu bod yn cael gwelliant clinigol bach yn unig, a bod y meddyg teulu o'r farn glinigol ei fod yn fuddsoddiad da ar gyfer yr unigolyn dan sylw, yna ei farn glinigol ef neu hi sy'n cyfrif. Nid yw hynny'n golygu na ellir profi barn glinigol i sicrhau bod iddi sail gadarn.

[68] **Jocelyn Davies:** The report points to some initiatives aimed at improving prescribing behaviour. Perhaps you would like to tell us about the progress in that area and how you are evaluating it.

[68] **Jocelyn Davies:** Mae'r adroddiad yn cyfeirio at rai mentrau sydd â'r nod o wella ymddygiad rhagnodi. Efallai yr hoffech ddweud wrthym am y cynnydd yn y maes hwnnw a sut yr ydych yn ei werthuso.

Ms Lloyd: I would like Carolyn to answer some of this because she is doing some of the evaluation. What we have to ensure is that prescribing is safe and effective—that is the beginning and end of the issue. The Welsh Medicines Resource Centre is, as you know, a source of independent advice on prescribing, and it is now very well used indeed. I think that we still need to get out to the GPs in their surgeries what help is available from that source to help to improve their prescribing, particularly as I am sure that the health authorities previously, and now the local health boards, will have been impressing upon the independent contractors the costs of prescribing and the fact that, if the prescribing budget is overspent, then that will come out of another element of patient care.

Ms Lloyd: Hoffwn i Carolyn ateb peth o hyn oherwydd ei bod yn gwneud rhywfaint o'r gwerthuso. Yr hyn y mae'n rhaid i ni ei sicrhau yw bod rhagnodi yn ddiogel ac yn effeithiol—dyna swm a sylwedd y mater. Mae Canolfan Adnoddau Moddion Cymru, fel y gwyddoch, yn ffynhonnell o gyngor annibynnol ar ragnodi, ac mae bellach yn cael llawer iawn o ddefnydd. Credaf fod dal angen i ni gyfleu i'r meddygon teulu yn eu meddygfeydd y cymorth sydd ar gael o'r ffynhonnell honno i gynorthwyo i wella'u rhagnodi, yn enwedig gan fy mod yn siŵr bod yr awdurdodau lleol yn flaenorol, a'r byrddau iechyd lleol bellach, wedi bod yn pwysleisio i'r contractwyr annibynnol gostau rhagnodi a'r ffaith, os oes gorwario ar y gyllideb ragnodi, yna y bydd hynny'n cael ei dynnu o elfen arall o ofal cleifion.

The development of local formularies is proving to be most effective. We now have to

Mae datblygu cyffurlyfrau lleol yn profi'n effeithiol iawn. Mae'n rhaid i ni bellach brofi

test whether or not local formularies are universally available throughout Wales. However, they have certainly made good progress, particularly in those areas where we are now seeing more salaried GPs, because there is a greater ability to start to have that dialogue.

ai yw cyffurlyfrau lleol ar gael yn gyffredinol ledled Cymru ai peidio. Fodd bynnag, maent yn sicr wedi gwneud cynnydd da, yn enwedig yn yr ardaloedd hynny lle'r ydym bellach yn gweld mwy o feddygon teulu cyflogedig, oherwydd bod mwy o allu i gynnal y deialog hwnnw.

There are prescribing incentive schemes and I would like Carolyn to discuss those and whether or not we have found that they really are going to make a difference to us. The prescribing advisers have been available through health authorities for at least 10 years. They are there to test the dispensing and the prescribing habits throughout the community and they have made considerable progress. They have also highlighted to GPs the changing drug regimes that are on the horizon so that they get a better understanding of what is about to come through. We also have a computer software system in existence that can be easily accessed by the prescribers. Would you like to talk about incentives, Carolyn?

Mae cynlluniau cymhellion rhagnodi a byddwn yn hoffi galw ar Carolyn i drafod y rheini ac a ydym wedi canfod eu bod mewn gwirionedd yn mynd i wneud gwahaniaeth i ni ai peidio. Mae'r ymgynghorwyr rhagnodi wedi bod ar gael drwy awdurdodau iechyd am o leiaf 10 mlynedd. Maent yno i brofi'r arferion dosbarthu a rhagnodi ledled y gymuned ac maent wedi gwneud cynnydd sylweddol. Maent hefyd wedi dwyn sylw meddygon teulu at y newidiadau i'r trefniadau cyffuriau sydd ar y gorwel fel eu bod yn cael gwell dealltwriaeth o'r hyn sydd ar fin dod i'r fei. Mae gennym hefyd system meddalwedd gyfrifadurol mewn bodolaeth y gall y rhagnodwyr gael mynediad hawdd iddi. A hoffech chi siarad am gymhellion, Carolyn?

Ms Poulter: Yes. Most local health groups have developed their own prescribing incentive schemes. They have been developed with the GPs. They will involve prescribing targets linked to certain prescribing indicators: for example, generic prescribing or, say, the use of drugs of limited clinical value, if you like. If the GPs meet the targets that are set within these prescribing incentive schemes, then I know that some local health groups have arrangements for the GPs to gain some of the financial savings that they have made—they will get some money back to spend on patient care. Therefore incentives such as that are in existence. The all-Wales prescribing advisory group that is soon to be set up will review all the prescribing incentive schemes that are in existence and evaluate whether they are providing good value for money. In terms of the feeling on the ground, the prescribing advisers tell me that they are very well received by the GPs and that they have had a considerable impact on improving both the quality and cost-effectiveness of prescribing.

Ms Poulter: Hoffwn. Mae'r mwyafrif o grwpiau iechyd lleol wedi datblygu eu cynlluniau cymhellion rhagnodi eu hunain. Maent wedi eu datblygu gyda'r meddygon teulu. Byddant yn cynnwys targedau rhagnodi sy'n gysylltiedig â dangosyddion rhagnodi penodol: er enghraifft, rhagnodi generig neu, o bosibl, defnyddio cyffuriau sydd â gwerth clinigol cyfyngedig, os hoffwch chi. Os yw'r meddygon teulu yn cwrdd â'r targedau a osodir yn y cynlluniau cymhellion rhagnodi hyn, yna gwn fod gan rai grwpiau iechyd lleol drefniadau i'r meddygon teulu gael rhywfaint o'r arbedion ariannol maent wedi eu gwneud—byddant yn cael peth arian yn ôl i wario ar ofal cleifion. Felly mae cymhellion tebyg mewn bodolaeth. Bydd y grŵp cynghori ar ragnodi Cymru gyfan, sydd i'w sefydlu'n fuan, yn adolygu'r holl gynlluniau cymhellion rhagnodi sy'n bodoli ac yn gwerthuso a ydynt yn cynnig gwerth da am arian. O ran y farn ar lawr gwlad, dywed y cynghorwyr rhagnodi wrthyf eu bod yn cael derbyniad da iawn gan feddygon teulu a'u bod wedi cael effaith sylweddol ar wella ansawdd rhagnodi a pha mor gost effeithiol ydyw.

[69] **Jocelyn Davies:** It may be considerable, but is it sufficient?

[69] **Jocelyn Davies:** Efallai ei fod yn sylweddol, ond a yw'n ddigonol?

Ms Poulter: That will be for the all-Wales prescribing advisory group to evaluate. Anything would be—

Ms Poulter: Bydd hynny i'w werthuso gan y grŵp cynghori ar ragnodi Cymru gyfan. Byddai unrhyw beth yn—

[70] **Jocelyn Davies:** What barriers are there? The potential savings are enormous and, as you say, could then be spent on initiatives other than drugs.

[70] **Jocelyn Davies:** Pa rwystrau sydd? Mae'r arbedion posibl yn enfawr ac, fel y dywedwch, gellid eu gwario wedyn ar fentrau heblaw cyffuriau.

Ms Poulter: The savings are there. The ones that are highlighted in the report are significant, but when you consider them against the total drug spend they are relatively small. However, obviously, any saving is good and, as I say, the all-Wales prescribing advisory group will evaluate the effect. However, the local health groups feel that they are very good value and that they have demonstrated improvements in prescribing in both quality as well as cost-effectiveness. They are continuing those schemes, which is evidence of the fact that they must be working. We need to evaluate them more formally.

Ms Poulter: Mae'r arbedion yno. Mae'r rhai sydd wedi eu crybwyll yn yr adroddiad yn sylweddol, ond maent yn gymharol fach pa fo'ch yn eu hystyried yn erbyn y cyfanswm sy'n cael ei wario ar gyffuriau. Fodd bynnag, yn amlwg, mae unrhyw arbediad yn dda ac, fel y dywedaf, bydd y grŵp cynghori ar ragnodi Cymru gyfan yn gwerthuso'r effaith. Fodd bynnag, mae'r grwpiau iechyd lleol yn teimlo eu bod yn werth da iawn a'u bod wedi dangos gwelliannau mewn rhagnodi o ran ansawdd a pha mor gost effeithiol ydyw. Maent yn parhau â'r cynlluniau hynny, sy'n dystiolaeth o'r ffaith bod yn rhaid eu bod yn gweithio. Mae angen i ni eu gwerthuso'n fwy ffurfiol.

[71] **Jocelyn Davies:** No doubt we will look at that when they have been evaluated, Chair.

[71] **Jocelyn Davies:** Mae'n siŵr y byddwn yn edrych ar hynny pan fyddant wedi cael eu gwerthuso, Gadeirydd.

[72] **Dafydd Wigley:** No doubt.

[72] **Dafydd Wigley:** Mae'n siŵr.

[73] **Jocelyn Davies:** The report states that over £15 million-worth of drugs every year is just wasted, because patients do not take them or throw them away or whatever. What progress is being made in improving medicines management?

[73] **Jocelyn Davies:** Mae'r adroddiad yn nodi bod gwerth dros £15 miliwn o gyffuriau bob blwyddyn yn cael eu gwastraffu, oherwydd nad yw cleifion yn eu cymryd neu'n eu taflu neu beth bynnag. Pa gynnydd sy'n cael ei wneud yn y gwaith o wella'r rheolaeth o feddyginiaethau?

Ms Lloyd: Well, this is a very tricky issue, because it is very much about culture, and patient behaviour as well. Certainly, we are looking very closely indeed at the repeat prescription regimes and I think that pharmacists can really play a major part, with their GP colleagues, in looking at that. Often, patients will behave in such a way—and I am sure that we have all done it—as to not finish the course, and, particularly if it is a course of antibiotics, you do not finish it because you feel better, so that is a waste. I think that we

Ms Lloyd: Wel, mae hwn yn fater lletchwith iawn, oherwydd mae'n ymwneud llawer â diwylliant, ac ymddygiad cleifion hefyd. Yn sicr, yr ydym yn edrych yn ofalus iawn ar y trefniadau ail-bresgripsiwn a chredaf y gall fferyllwyr chwarae rhan bwysig iawn, gyda'u cydweithwyr ym maes meddygaeth deuluol, wrth edrych ar hynny. Yn aml, bydd cleifion yn ymddwyn yn y fath fodd—ac yr wyf yn siŵr ein bod ni bob un wedi ei wneud—fel nad ydynt yn gorffen y cwrs, ac, yn enwedig os mai cwrs o wrthfiotigau yw, nid ydych yn

need to improve the information that we give to patients about the use of their drugs. Some patients cannot take a particular drug that is prescribed for them, so it is really important that, again, a discussion goes on between the general practitioner and the patient. However, we have plans afoot at the moment to work with the pharmaceutical companies to try to ensure that medicines management is brought to the forefront. We have to ensure—and I think that the basis of it is repeat prescriptions—that there is a much better system, whereby if a prescription is to be repeated, there is a review of the requirement for that particular set of drugs. We also have to ensure that the professional services are available to the GPs and to the patients to allow that to take place, because we have to try to ensure that waste is absolutely limited.

ei orffen oherwydd eich bod yn teimlo'n well, felly mae hynny'n wastraff. Credaf fod angen i ni wella'r wybodaeth y rhown i gleifion am y defnydd o'u cyffuriau. Ni all rhai cleifion gymryd cyffur penodol sy'n cael ei ragnodi iddynt, felly mae'n bwysig iawn, unwaith eto, bod trafodaeth rhwng y meddyg teulu a'r claf. Fodd bynnag, mae gennym gynlluniau ar droed ar hyn o bryd i weithio gyda chwmnïau fferyllol i geisio sicrhau bod blaenoriaeth yn cael ei rhoi i reoli meddyginiaethau. Rhaid i ni sicrhau—a chredaf mai sail hyn yw ail-bresgripsiynau—bod system lawer gwell, lle os yw presgripsiwn yn mynd i gael ei ail-ragnodi, bod adolygiad o'r gofyniad am y set benodol honno o gyffuriau. Rhaid i ni hefyd sicrhau bod y gwasanaethau proffesiynol ar gael i'r meddygon teulu a'r cleifion i alluogi hynny i ddigwydd, oherwydd rhaid i ni geisio sicrhau bod cyn lleied o wastraff â phosibl.

There has been a huge discussion going on about prescription packs and whether or not if something is prescribed for 28 days and there are 30 tablets in a pack that is a waste. Well, it may or may not be. Most pharmacists will manage that quite carefully, but, again, that is set against the risk of having two odd tablets in a pack in the box, and do you actually have the name of the drug on the pack that is left? So, we have to be careful in terms of quality and risk, but there is much more that can be done on an individual basis and there is a big drive going on at the moment about repeat prescriptions and their proper management.

Bu trafod helaeth am becynnau presgripsiwn ac a yw'n wastraff ai peidio os yw rhywbeth yn cael ei ragnodi am 28 diwrnod ac mae 30 tabled mewn pecyn. Wel, efallai ei fod yn wastraff neu efallai nad yw. Bydd y mwyafrif o fferyllwyr yn rheoli hynny'n eithaf ofalus, ond, eto, rhoddir hynny'n erbyn y risg o gael dwy dabled dros ben mewn pecyn yn y bocs, ac a oes gennych mewn gwirionedd enw'r cyffur ar y pecyn sy'n weddill? Felly, rhaid i ni fod yn ofalus o ran ansawdd a risg, ond mae llawer mwy y gall unigolion ei wneud ac mae ymdrech fawr ar y gweill ar hyn o bryd sy'n rhoi sylw i ail-bresgripsiynau a'r rheolaeth gywir ohonynt.

[74] **Jocelyn Davies:** So repeat prescriptions, you think, are the main cause of that waste. What about the patients who may not want to have generics and who may waste them? Have you any evidence that that is a significant factor?

[74] **Jocelyn Davies:** Felly ail-bresgripsiynau, yn eich tŷb chi, yw prif achos y gwastraff hynny. Beth am gleifion nad ydynt, o bosibl, am gael cyffuriau generig ac a fydd, o bosibl, yn eu gwastraffu? A oes gennych unrhyw dystiolaeth fod hynny'n ffactor arwyddocaol?

Ms Poulter: I have no evidence that it is a significant factor. It is down to communication between the GP and the patient, and also between the community pharmacist and the patient, to ensure that the patient understands that, although the tablets might look different, they are actually the same, are produced to the same standard and will do the same job.

Ms Poulter: Nid oes gennyf unrhyw dystiolaeth fod hynnyn ffactor arwyddocaol. Mae'n dibynnu ar y cyfathrebu rhwng y meddyg teulu a'r claf, a hefyd rhwng y fferyllydd cymuned a'r claf, i sicrhau bod y claf yn deall, er bod tabledi yn edrych yn wahanol, eu bod mewn gwirionedd yr un fath, yn cael eu cynhyrchu i'r un safon ac y byddant yn gwneud yr un fath.

[75] **Eleanor Burnham:** Can I just press you briefly for an example of a medicine of limited clinical value? Who is it thatdetermines what is of good or limited clinical value?

[75] **Eleanor Burnham:** A gaf eich holi'n fyr am enghraifft o feddyginiaeth sydd â gwerth clinigol cyfyngedig? Pwy sy'n pennu beth sydd â gwerth clinigol da neu werth cyfyngedig?

Ms Poulter: I think that the classic ones are some bitters and tonics that can be prescribed for indigestion; those sort of simple indigestion remedies, perhaps. That would be an example. They are actually marked in the British national formulary, those drugs that are considered to be of limited clinical value, and I think that the decision is made based on the views of the British Medical Association and the Royal Pharmaceutical Society, but I am not actually too sure about that—

Ms Poulter: Credaf mai'r rhai clasurol yw rhai chwerwon a thonigau y gellir eu rhagnodi ar gyfer diffyg traul: y mathau hynny o feddyginiaethau diffyg traul syml, efallai. Byddai hynny yn enghraifft. Maent wedi eu nodi mewn gwirionedd yng nghyffurlyfr cenedlaethol Prydain, y cyffuriau hynny a ystyrir i fod â gwerth clinigol cyfyngedig, a chredaf y gwneir y penderfyniad yn seiliedig ar safbwyntiau Cymdeithas Feddygol Prydain a'r Gymdeithas Fferyllol Frenhinol, ond nid wyf mewn gwirionedd yn rhy siŵr ynglŷn â hynny—

[76] **Eleanor Burnham:** Would that be influenced at all by the pharmaceutical companies so that, perhaps, it would appear that it was better to use their expensive drugs as opposed to something such as that you have just mentioned, that was relatively cheap?

[76] **Eleanor Burnham:** A fyddai'r cwmnïau fferyllol yn dylanwadu ar hynny o gwbl fel, efallai, y byddai'n ymddangos ei bod yn well defnyddio'u cyffuriau drud hwy yn hytrach na rhywbeth tebyg i'r hyn yr ydych newydd sôn amdano, a oedd yn gymharol rad?

Ms Poulter: No. In terms of those drugs that are marked as of limited clinical value, it is just based on current evidence, and often that evidence changes.

Ms Poulter: Na. O ran y cyffuriau hynny sydd wedi eu nodi eu bod â gwerth clinigol cyfyngedig, mae'n seiliedig ar dystiolaeth gyfredol yn unig, ac yn aml mae'r dystiolaeth honno'n newid.

[77] **Dafydd Wigley:** Janet, do you want to come in with a brief question here? Then Ann, then Alison.

[77] **Dafydd Wigley:** Janet, a ydych am ddod i mewn gyda chwestiwn byr yma? Wedyn Ann, wedyn Alison.

[78] **Janet Davies:** This is a rather sensitive question to ask, but is there any evidence at all as to whether wastage of drugs is more or less likely if prescriptions are free rather than paid for?

[78] **Janet Davies:** Mae hwn yn gwestiwn braidd yn sensitif i'w ofyn, ond a oes unrhyw dystiolaeth o gwbl ynghylch a yw gwastraffu cyffuriau yn fwy neu'n llai tebygol os yw presgripsiynau am ddim yn hytrach na bod tâl amdanynt?

Ms Lloyd: No-one has done any work on that. As you know, in Wales, there is a large number of people anyway who would always have had free prescriptions. I simply cannot answer that.

Ms Lloyd: Nid oes neb wedi gwneud unrhyw waith ar hynny. Fel y gwyddoch, yng Nghymru, mae nifer fawr o bobl beth bynnag a fyddai wastad wedi cael presgripsiynau am ddim. Ni allaf ateb hynny, yn syml.

[79] **Dafydd Wigley:** That probably goes beyond the scope of this report, does it not?

[79] **Dafydd Wigley:** Mae hynny yn ôl pob tebyg yn mynd y tu hwnt i gwmpas yr

No doubt it is a consideration that the Government will have, in its broadest context. Ann, did you want to come in before we move on?

adroddiad hwn, onid ydyw? Mae'n siŵr y bydd yn ystyriaeth y bydd gan y Llywodraeth, yn ei chyd-destun ehangaf. Ann, a oeddech am gyfrannu cyn i ni symud ymlaen?

[80] **Ann Jones:** Yes. It was on the repeat prescription. You sort of highlighted that as being probably one of the major players in wastage. Should we not be looking to utilise the pharmacist in a way, certainly in hospitals, because that is where most prescribing will start? You are prescribed a drug, you come out with a pack to go home with, and then you go to your GP and it is all repeated. Could the hospital pharmacist be utilised more to cut down on some of the wastage of drugs, even in hospitals?

[80] **Ann Jones:** Oeddwn. Yr oedd yn ymwneud ag ail-bresgripsiynau. Bu i chi fwy neu lai amlygu hwnnw fel un o'r prif ffactorau gwastraff yn ôl pob tebyg. Oni ddylem ystyried defnyddio'r fferyllydd mewn modd, yn bendant mewn ysbytai, oherwydd dyna lle fydd y rhan fwyaf o ragnodi yn dechrau? Mae cyffur yn cael ei ragnodi i chi, dewch allan gyda phecyn i fynd adref gyda chi, ac yna yr ydych yn mynd at eich meddyg teulu ac mae'r cyfan yn ailddechrau. A ellid defnyddio mwy ar y fferyllydd ysbyty i leihau rhywfaint ar y gwastraffu cyffuriau, hyd yn oed mewn ysbytai?

Ms Poulter: Yes, absolutely. Hospital pharmacists do review patients' medication. They have an ideal opportunity to review patients' medication while they are in bed. So, yes.

Ms Poulter: Gellid, yn bendant. Mae fferyllwyr ysbyty yn adolygu meddyginiaeth cleifion. Mae ganddynt gyfle delfrydol i adolygu meddyginiaeth cleifion tra'u bod yn y gwely. Felly, gellid.

[81] **Ann Jones:** So we should develop that role? The role of the hospital pharmacist should be developed far more than it is in certain areas now?

[81] **Ann Jones:** Felly dylasem ddatblygu'r rôl honno? Dylid datblygu rôl y fferyllydd ysbyty llawer mwy nag y mae mewn rhai ardaloedd ar hyn o bryd?

Ms Poulter: I would argue that the role of the hospital pharmacist is quite well-developed, actually, far more so than that of the community pharmacist.

Ms Poulter: Byddwn yn dadlau bod rôl y fferyllydd ysbyty yn eithaf datblygedig, mewn gwirionedd, llawer mwy na rôl y fferyllydd cymuned.

[82] **Ann Jones:** Okay.

[82] **Ann Jones:** O'r gorau.

[83] **Dafydd Wigley:** Is there good enough co-ordination between the hospital pharmacist and the community pharmacist?

[83] **Dafydd Wigley:** A oes cyd-drefnu digon da rhwng y fferyllydd ysbyty a'r fferyllydd cymuned?

Ms Poulter: I think that it could be improved. The difficulty is that patients can go to any pharmacy that they want.

Ms Poulter: Credaf y gellid ei wella. Yr anhawster yw y gall cleifion fynd i unrhyw fferyllfa y dymunant.

[84] **Dafydd Wigley:** Yes, of course. Alison, did you want to come in?

[84] **Dafydd Wigley:** Ie, wrth gwrs. Alison, a ydych am ddod i mewn?

[85] **Alison Halford:** I am just curious. How on earth can anybody determine that £15.6 million-worth of medicine is wasted? Unless you go to someone's medicine cabinet and find half a pack of Feldene or something,

[85] **Alison Halford:** Yr wyf yn chwilfrydig. Sut ar y ddaear gall unrhyw un bennu bod gwerth £15.6 miliwn o feddyginiaeth wedi'i gwastraffu? Oni bai eich bod yn mynd i gwpwrdd moddion rhywun a dod o hyd i

how do you actually quantify waste?

hanner pecyn o Feldene neu rywbeth, sut yr ydych yn mesur gwastraff mewn gwirionedd?

Ms Lloyd: There have been some dump campaigns recently, and from those dump campaigns this is the sort of figure that is being highlighted. The fact that some people would choose not to dump even would lead to a margin of error. However, I think that everyone recognises that there is an issue about this.

Ms Lloyd: Bu rhai ymgyrchoedd dympio yn ddiweddar, a dyma'r math o ffigur sy'n cael ei amlygu o'r ymgyrchoedd dympio hynny. Mae'r ffaith y byddai rhai pobl yn dewis peidio â dympio hyd yn oed yn gadael lle i wallau. Fodd bynnag, credaf fod pawb yn cydnabod bod hwn yn fater i'w drafod.

[86] **Alison Halford:** Thank you for that. On repeat prescriptions, if you have arthritis, a condition which deteriorates, then, clearly, repeat prescriptions are going to be the order of the day. Again, how do you distinguish between those chronic cases and those people who actually have a problem and then just continue taking the pills because they think that it is going to be good for them, although they are better? How do you actually break down the dangers? You are talking about big drives on repeat prescriptions. What are you actually trying to achieve? I know that you are looking for savings.

[86] **Alison Halford:** Diolch i chi am hynny. Ynghylch ail-bresgripsiynau, os oes gennych arthritis, cyflwr sy'n gwaethygu, yna, yn amlwg, bydd ail-bresgripsiynau yn angenrheidiol. Eto, sut yr ydych yn gwahaniaethu rhwng yr achosion cronig hynny a'r bobl hynny sy'n wirioneddol â phroblem ac sy'n parhau i gymryd y pils oherwydd eu bod yn credu eu bod yn mynd i wneud daioni iddynt, er eu bod yn well? Sut yr ydych yn goresgyn y peryglon? Yr ydych yn sôn am ymgyrchoedd mawr i fynd i'r afael ag ail-bresgripsiynau. Beth yr ydych yn ceisio ei gyflawni mewn gwirionedd? Gwn eich bod yn chwilio am arbedion.

Ms Lloyd: Well, not just savings; it is about effective management of the patient. Of course, people who have chronic illness will have continuing prescribing needs. However, the prescription might change over time. Really, we are pushing for very good evaluation of the patients and not just 'so-and-so wants a repeat prescription'. I know that people are very hard-pressed—

Ms Lloyd: Wel, nid arbedion yn unig; mae'n ymwneud â rheoli'r claf yn effeithiol. Wrth gwrs, bydd gan bobl sydd ag afiechyd cronig anghenion presgripsiwn parhaus. Fodd bynnag, efallai y bydd y presgripsiwn yn newid dros amser. Yn y bôn, yr ydym yn pwyso am werthusiad da iawn o gleifion ac nid 'mae angen ail-bresgripsiwn ar hwn a'r llall' yn unig. Gwn fod pobl dan bwysau mawr—

[87] **Alison Halford:** I think that Carolyn is going to make a point on your behalf.

[87] **Alison Halford:** Credaf fod Carolyn yn mynd i wneud pwynt ar eich rhan.

Ms Lloyd: Yes. She is going to talk about side effects.

Ms Lloyd: Ydyw. Mae hi'n mynd i sôn am sgîl-effeithiau.

Ms Poulter: It is all about regular ongoing monitoring of patient compliance, side effects and the efficacy of the drug. That is where the pharmacist really can play a major role, so that patients do not just order their repeat medicines and continue without any follow-up.

Ms Poulter: Mae'r cyfan yn ymwneud â monitro cydymffurfiaeth cleifion yn barhaus a rheolaidd, sgîl-effeithiau ac effeithiolrwydd y cyffur. Dyna lle gall y fferyllydd mewn gwirionedd chwarae rôl bwysig, fel nad yw cleifion ond yn archebu eu meddyginiaethau dro ar ôl tro ac yn parhau heb unrhyw ddilyniant.

[88] **Jocelyn Davies:** May I ask a question on

[88] **Jocelyn Davies:** A gaf fi ofyn cwestiwn

that?

[89] **Dafydd Wigley:** Yes, and we will then go back to Alison.

[90] **Jocelyn Davies:** Does this also involve patients who may have three or four items on repeat prescription, and continue to get the three or four items but are only taking one of them, and the other three are just getting stockpiled in the cupboard?

Ms Lloyd: Yes.

[91] **Dafydd Wigley:** Right. Point well made. Alison?

[92] **Alison Halford:** I have one question on the involvement of pharmacists in medication reviews, which can help to avoid the risk of adverse reactions. Is it a good idea, and how are these widespread reviews working? Are they working?

Ms Poulter: Yes. Many, or most local health groups, have prescribing advisers and pharmacy technicians who work with GPs, and they will often go into a GP's practice and target patients who are on, for example, 10 prescription items or more. They invite them into the surgery to discuss their medication with them to see whether all the drugs are required, whether they are experiencing side effects and whether they are getting good benefit from their medicines. That happens now. Community pharmacists will do that to some extent; it is perhaps on an ad hoc basis, but it does occur. What we need to do is to formalise that and encourage and remunerate pharmacists for doing it.

[93] **Alison Halford:** So how can these reviews be made more widespread, and how long will we have to wait for that?

Ms Poulter: We have started negotiations on a new pharmacy contract, and we are looking to remunerate pharmacists for these professional services, rather than just remunerating them for dispensing high volumes of prescriptions, to demonstrate that we value this service that pharmacists

am hynny?

[89] **Dafydd Wigley:** Cewch, ac yna awn yn ôl at Alison.

[90] **Jocelyn Davies:** A yw hyn hefyd yn cynnwys cleifion sydd o bosibl â thair neu bedair eitem ar ail-bresgripsiwn, ac yn parhau i gael y tair neu bedair eitem ond yn cymryd un ohonynt yn unig, gyda'r tri arall ond yn pentyrru yn y cwpwrdd?

Ms Lloyd: Ydyw.

[91] **Dafydd Wigley:** O'r gorau. Yr oedd hwnnw'n bwynt da. Alison?

[92] **Alison Halford:** Mae gennyf un cwestiwn am ran fferyllwyr yn y gwaith o adolygu meddyginiaethau, sy'n gallu cynorthwyo i osgoi'r risg o adweithio andwyol. A yw'n syniad da, a sut mae'r adolygiadau eang hyn yn gweithio? A ydynt yn gweithio?

Ms Poulter: Ydynt. Mae gan lawer, neu'r mwyafrif o grwpiau iechyd lleol, gynghorwyr rhagnodi a thechnegwyr fferyllfa sy'n gweithio gyda meddygon teulu, a byddant yn aml yn mynd i bractis meddyg teulu ac yn targedu cleifion sydd , er enghraifft, ar 10 eitem bresgripsiwn neu fwy. Maent yn eu gwahodd i'r feddygfa i drafod eu meddyginiaeth gyda hwy i weld a oes angen yr holl gyffuriau, a ydynt yn dioddef unrhyw sgîl-effeithiau ac a ydynt yn cael budd da o'u meddyginiaethau. Mae hynny'n digwydd yn awr. Bydd fferyllwyr cymuned yn gwneud hynny i ryw raddau; efallai ei fod yn ad hoc, ond mae yn digwydd. Yr hyn sydd ei angen i ni ei wneud yw ffurfioli hynny ac annog a gwobrwyo fferyllwyr am ei wneud.

[93] **Alison Halford:** Felly sut y gellir gwneud yr adolygiadau hyn yn fwy cyffredin, a pha mor hir y bydd yn rhaid inni aros am hynny?

Ms Poulter: Yr ydym wedi dechrau negodiadau ar gontract fferyllfa newydd, ac yr ydym yn bwriadu gwobrwyo fferyllwyr am y gwasanaethau proffesiynol hyn, yn hytrach na'u gwobrwyo am ddosbarthu llawer o bresgripsiynau yn unig, i ddangos ein bod yn gwerthfawrogi'r gwasanaeth hwn

provide.

[94] **Janice Gregory:** There is obviously patient education involved in this because the repeat prescriptions that I have seen are different from how they used to be. You now have to actually tick them. So if you have a list of 10 or 15 medications on a repeat prescription, you now have to indicate the ones that you want a repeat prescription for. I quite accept that most people will just tick every box because it is easier than reading them maybe, or they just want them all. Therefore, there must be a public information campaign of some sort for the patient. I do not know whether we can expect GPs, with all the pressures that are upon them, to sit down with their patients and say, ‘please do not tick every box if you do not require it’. I just wanted to make that point.

[95] **Dafydd Wigley:** Val, your question has been partly picked up, but there are other aspects to it. Can you take that on now?

[96] **Val Lloyd:** Yes, it is slightly different. I was going to refer to the fact that you mentioned pack size standardisation. I have a slightly different line of questioning on that. It does seem to be a sensible way of improving value for money. Could you tell us what has prevented this from being done sooner, and how do you intend to overcome any obstacles to moving it forward?

Ms Lloyd: Could I just clarify the question? Do you mean having pack size—

[97] **Val Lloyd:** Standardisation.

Ms Lloyd: What has prevented us doing it in the past, I cannot say. There have been lots and lots of different initiatives in terms of proper dispensing, an awful lot of which were, quite rightly, driven by improved quality in the management of risk. You will have seen the initiatives, coming from the hospital sector as well, whereby people who might get confused, if they are on a number of tablets, about which day they are on and

y mae fferyllwyr yn ei ddarparu.

[94] **Janice Gregory:** Mae’n amlwg bod addysg cleifion yn ymwneud â hyn oherwydd mae’r ail-bresgripsiynau yr wyf wedi eu gweld yn wahanol i’r hyn yr arferent fod. Mae’n rhaid i chi eu ticio bellach. Felly os oes gennych restr o 10 neu 15 o feddyginiaethau ar ail-bresgripsiwn, bellach mae’n rhaid i chi nodi’r rhai yr ydych angen ail-bresgripsiwn ar eu cyfer. Yr wyf yn derbyn yn llwyr y bydd y mwyafrif o bobl yn ticio pob bocs oherwydd mae’n haws na’u darllen efallai, neu mae eu hangen hwy i gyd arnynt. Felly, rhaid cael ymgyrch gwybodaeth gyhoeddus o ryw fath ar gyfer y claf. Ni wn a allwn ddisgwyl i feddygon teulu, gyda’r holl bwysau sydd arnynt, eistedd gyda’u cleifion a dweud, ‘peidiwch â thicio pob bocs os nad oes ei angen arnoch’. Yr oeddwn am wneud y pwynt hwnnw.

[95] **Dafydd Wigley:** Val, mae’ch cwestiwn wedi cael ei drafod yn rhannol, ond mae agweddau eraill arno. A allwch chi ofyn hwnnw yn awr?

[96] **Val Lloyd:** Ydyw, mae ychydig yn wahanol. Yr oeddwn yn mynd i gyfeirio at y ffaith eich bod wedi crybwyll safoni maint pecynnau. Mae gennyf gwestiynau ychydig yn wahanol am hynny. Mae’n ymddangos yn fodd synhwyrol o wella gwerth am arian. A allech ddweud wrthym beth sydd wedi rhwystro hyn rhag cael ei wneud yn gynharach, a sut yr ydych yn bwriadu goresgyn unrhyw rwystrau i’r gwaith o’i ddatblygu?

Ms Lloyd: A allaf wneud y cwestiwn yn glir? A ydych yn golygu cael maint pecynnau—

[97] **Val Lloyd:** Safonol.

Ms Lloyd: Beth sydd wedi ein rhwystro rhag ei wneud yn y gorffennol, ni allaf ddweud. Bu llawer iawn o fentrau gwahanol o ran dosbarthu cywir, gyda llawer iawn ohonynt, yn hollol gywir, yn cael eu hyrwyddo gan well ansawdd yn y gwaith o reoli risg. Byddwch wedi gweld y mentrau hyn, a ddawo’r sector ysbyty hefyd, lle y bydd pobl a allai ddrysu, os ydynt yn cymryd nifer o dabledi, ynglŷn â pha ddiwrnod y maent arno

whether or not they have taken their tablets at the right time, have these sort of almost automated packs so that they are able to keep track of their medicines. All of those are really good things—not only do they improve the patient's ability to take his or her medicines, and therefore not waste them, but they allow ourselves, the hospitals, and the GPs, to ensure that patients are taking the right medicines at the right time and not getting in a jumble about it. They are really good. In terms of the packs, one of the great advantages of them is that they have the names of what you are taking on them. That, again, is a security issue. From the hospital point of view, the downside of packs, certainly when they were first produced, was that the hospitals were going towards only, for example, giving seven days' worth of take-home drugs and, all of a sudden, 28-day packs were appearing. That caused a problem, but there was a lot of discussion between the two sectors about how that would be managed, and it certainly ensures that patients will take the right course of drugs, because their drugs are all set out for them and they can tell when they have missed a day or a dose and so on. So, again, it is an issue of the management of risk and an improvement in quality. The downside is that you can get greater waste from it. However, in terms of dispensing, most of the pharmacists anyway will retain drugs not dispensed in a safe environment and they will be dispensed normally by that individual as part of a prescription. So, I think that, although there was a lot of controversy when it started, the system has settled down and I think that we basically feel that we are dealing with an improved quality.

ac a ydynt wedi cymryd eu tabledi ar yr amser cywir ai peidio, yn cael y math o becynnau hyn sydd bron yn awtomataidd fel eu bod yn gallu cadw cyfrif o'u meddyginiaethau. Mae'r rheini i gyd yn bethau da iawn—nid yn unig maent yn gwella gallu'r claf i gymryd ei feddyginiaethau neu ei meddyginiaethau, ac felly peidio â'u gwastraffu, ond maent yn caniatáu i ni, yr ysbytai, a'r meddygon teulu, i sicrhau bod cleifion yn cymryd y meddyginiaethau cywir ar yr amser cywir ac nad ydynt yn drysu yn eu cylch. Maent yn dda iawn. O ran y pecynnau, un o'u manteision mawr yw bod enwau yr hyn yr ydych yn ei gymryd arnynt. Mae hynny, eto, yn fater diogelwch. O safbwynt yr ysbyty, anfantais y pecynnau, yn sicr pan y'u cynhyrchwyd yn y lle cyntaf, oedd bod yr ysbytai yn tueddu, er enghraifft, i roi gwerth saith niwrnod o gyffuriau yn unig i fynd adref ac, yn sydyn, yr oedd pecynnau 28-diwrnod yn ymddangos. Achosodd hynny broblem, ond bu llawer o drafod rhwng y ddau sector ynglŷn â sut y byddai hynny'n cael ei reoli, ac mae'n bendant yn sicrhau y bydd cleifion yn cymryd y cwrs cywir o gyffuriau, oherwydd mae eu cyffuriau wedi eu gosod allan ar eu cyfer a gwyddant os ydynt wedi colli diwrnod neu ddos ac ati. Felly, eto, mae'n fater o reoli'r risg a gwella ansawdd. Yr anfantais yw y gallwch gael mwy o wastraff oddi wrtho. Fodd bynnag, o ran dosbarthu, bydd y mwyafrif o'r fferyllwyr beth bynnag yn cadw cyffuriau na chânt eu dosbarthu mewn amgylchedd diogel a byddant yn cael eu dosbarthu fel arfer gan yr unigolyn hwnnw fel rhan o bresgripsiwn. Felly, credaf, er y bu llawer o ddadlau pan ddechreuodd y system, mae wedi dod i drefn a chredaf ein bod yn y bôn yn teimlo ein bod yn delio ag ansawdd gwell.

[98] **Val Lloyd:** I find that very helpful, but I was actually thinking about the last sentence in paragraph 4.34:

[98] **Val Lloyd:** Mae hynny'n ddefnyddiol iawn i mi, ond yr oeddwn mewn gwirionedd yn meddwl am y frawddeg olaf ym mharagraff 4.34:

'It would help to reduce the barrier to substituting one medicine for another caused by differences in pack size.'

'Byddai o gymorth i leihau'r rhwystr i amnewid un feddyginiaeth am un arall a achosir gan wahaniaethau ym maint pecynnau.'

Certain items will come in packs of 30 and perhaps they will be dispensed in a 28-day

Bydd rhai eitemau yn dod mewn pecynnau o 30 ac efallai y byddant yn cael eu dosbarthu

course, as you mentioned earlier—cutting off two, which would then be lost. However, I am looking at it in a different way, in terms of when we can substitute one medicine for another quite properly.

mewn cwrs 28-diwrnod, fel y soniasoch yn gynharach—gan adael dau yn weddill a fyddai wedyn yn cael eu colli. Fodd bynnag, yr wyf yn edrych arno mewn modd gwahanol, o ran pryd y gallwn amnewid un feddyginiaeth am un arall yn hollol briodol.

Ms Poulter: The problem is that the packs are made for a global market—the packs of 28 and 30. There is no standardisation and, although perhaps in the UK we would prefer standardisation to pack sizes of 28, I believe that certain European countries would prefer them to be in packs of 30. Wales, as a small player, has limited influence over the pharmaceutical industry to produce a standard pack size. However, we are setting up a NHS industry forum whereby NHS staff and the pharmaceutical industry can come together and discuss such issues. We hope that we will be able to influence this in that way.

Ms Poulter: Y broblem yw bod pecynnau yn cael eu gwneud ar gyfer marchnad fyd-eang—y pecynnau o 28 a 30. Nid oes safoni ac, er efallai y byddem yn ffafrio safoni i becynnau o 28 yn y DU, credaf y byddai'n well gan rai gwledydd Ewropeaidd iddynt fod mewn pecynnau o 30. Dylanwad cyfyngedig sydd gan Gymru, fel chwaraewr bach, ar y diwydiant fferyllol i gynhyrchu pecyn o faint safonol. Fodd bynnag, yr ydym yn sefydlu fforwm diwydiant y GIG lle gall staff y GIG a'r diwydiant fferyllol ddod at ei gilydd a thrafod y cyfryw faterion. Yr ydym yn gobeithio y byddwn yn gallu dylanwadu ar hyn yn y modd hwnnw.

[99] **Val Lloyd:** Thank you, Chair. I think that that is all.

[99] **Val Lloyd:** Diolch yn fawr, Gadeirydd. Credaf mai dyna'r cyfan.

[100] **Dafydd Wigley:** Did you have a brief comment, Eleanor?

[100] **Dafydd Wigley:** A oedd gennych sylw byr, Eleanor?

[101] **Eleanor Burnham:** I had the pleasure of going round Boots in Wrexham where they showed me their care management for nursing homes and residential homes. My concern is that Boots is in a very strong position. Do you envisage helping smaller, independent community pharmacists and, perhaps, as you said earlier, remunerating them for all the extra work that is involved in all these care management plans?

[101] **Eleanor Burnham:** Cefais y pleser o fynd o amgylch Boots yn Wrecsam lle dangosant i mi eu rheolaeth ar ofal ar gyfer cartrefi nyrsio a chartrefi preswyl. Fy mhryder yw bod Boots mewn sefyllfa gref iawn. A ydych yn rhagweld cynorthwyo fferyllwyr cymuned annibynnol, llai ac, efallai, fel y dywedasoch yn gynharach, eu gwobrwyo am yr holl waith ychwanegol sy'n gysylltiedig â'r holl gynlluniau rheoli gofal hyn?

Ms Poulter: We will be looking at remunerating pharmacists for these additional professional services through the new pharmacy contract.

Ms Poulter: Byddwn yn edrych ar wobrwyo fferyllwyr am y gwasanaethau proffesiynol ychwanegol hyn drwy'r contract fferyllfa newydd.

[102] **Dafydd Wigley:** That is part of the review that you are doing at the moment. Janet, did you have something that you wanted to bring in before we pull things together?

[102] **Dafydd Wigley:** Mae hynny'n rhan o'r adolygiad yr ydych yn ei wneud ar hyn o bryd. Janet, a oedd gennych rywbeth yr oeddech am ei ddweud cyn inni gloi?

[103] **Janet Davies:** Yes. Reading the report as a whole, two things struck me in a sort of broad, overall way. One was the complexity

[103] **Janet Davies:** Oedd. O ddarllen yr adroddiad yn ei gyfanrwydd, cefais fy nharo gan ddau beth mewn rhyw fath o fodd

of the issue, which has been talked about. The other was that there are quite a number of organisations that are reviewing and considering this matter. Do you feel that there is any duplication among the organisations, or do they all have a different and valid role?

cyffredinol, eang. Un oedd cymhlethdod y mater, sydd wedi cael ei drafod. Y llall oedd fod cryn nifer o sefydliadau sy'n adolygu ac yn ystyried y mater hwn. A ydych yn teimlo bod unrhyw ddyblygu ymhlith y sefydliadau, neu a oes ganddynt i gyd rôl wahanol a dilys?

Ms Lloyd: In discussing this with Carolyn, we think that there is no duplication because people are actually keeping in contact with each other. They all have a valid role in looking at this very complex system to ensure that we are all getting best value for money and that patient safety remains at the forefront of the discussion. So, we are sharing information among ourselves about the various aspects that are being reviewed.

Ms Lloyd: Wrth drafod hyn gyda Carolyn, credwn nad oes dyblygu oherwydd bod pobl mewn gwirionedd yn cadw mewn cysylltiad â'i gilydd. Mae ganddynt oll rôl ddilys yn y gwaith o edrych ar y sefyllfa dra chymhleth hon i sicrhau ein bod ni i gyd yn cael gwerth gorau am arian a bod diogelwch y claf yn parhau'n flaenoriaeth yn y drafodaeth. Felly, yr ydym yn rhannu gwybodaeth ymhlith ein hunain am y gwahanol agweddau sy'n cael eu hadolygu.

[104] **Dafydd Wigley:** Good. Incidentally, for the benefit of colleagues, I will try to fit in another item before the coffee break, if I can. However, in conclusion, I am certainly impressed, and I think that my colleagues are impressed, by the positive attitude that you are taking towards this matter, and I would like to thank you for that. However, may I ask, in approaching a very complex subject—containing as it does a significant number of vested interests and some pretty big battalions with whom the changes have to be negotiated—do you and your colleagues have the stomach for that fight? At the very least to get the pilot schemes up and running, which can, hopefully, then indicate that substantial savings could be achieved without any great loss in terms of disruption or loss of service and, in a way, it could be a trailblazer for the rest of the UK, for it to emulate progress being made in Wales. Do you have the stomach for that fight?

[104] **Dafydd Wigley:** Iawn. Gyda llaw, er budd cyd-Aelodau, ceisiaf gynnwys eitem arall cyn yr egwyl goffi, os gallaf. Fodd bynnag, i gloi, cefias argraff dda, a chredaf i'm cyd-Aelodau gael argraff dda, am yr agwedd gadarnhaol yr ydych yn ei chymryd ar y mater hwn, a hoffwn ddiolch i chi am hynny. Fodd bynnag, a gaf fi ofyn, o fynd i'r afael â phwnc cymhleth iawn—sy'n cynnwys fel y mae nifer sylweddol o fuddiannau a rhai lluoedd eithaf mawr y mae'n rhaid negodi'r newidiadau gyda hwy—a oes gennych chi a'ch cydweithwyr y stumog ar gyfer y frwydr honno? Yn y man lleiaf i roi'r cynlluniau peilot ar waith, a fydd wedyn, gobeithio, yn gallu nodi y gellid sicrhau arbedion sylweddol heb unrhyw golled fawr o ran amharu ar neu golli gwasanaeth ac, mewn ffordd, y gallai fod yn esiampl ar gyfer gweddill y DU, fel ei bod yn ceisio efelychu'r cynnydd sy'n cael ei wneud yng Nghymru. A oes gennych y stumog ar gyfer y frwydr honno?

Ms Lloyd: We always have the stomach for an active discussion with our partners. I think that, if the Auditor General says that there are ways in which moneys can be saved to be reinvested in patient care, then we must explore those seriously. As he has very helpfully pointed out, there are a number of risks surrounding this and that is an issue on which the all-Wales medicines strategy group will advise us, before we launch any pilot schemes, to ensure that we protect the system. We do not want anything falling

Ms Lloyd: Mae gennym bob amser y stumog ar gyfer trafodaeth weithredol gyda'n partneriaid. Credaf, os dywed yr Archwilydd Cyffredinol fod ffyrdd y gellid arbed arian i'w ail-fuddsoddi yng ngofal cleifion, yna fod yn rhaid i ni archwilio'r rheini o ddifrif. Fel y mae wedi nodi'n ddefnyddiol, mae nifer o risgiau yn gysylltiedig â hyn ac mae hwnnw'n fater y bydd y grŵp strategaeth meddyginiaethau Cymru gyfan yn ein cynghori arno, cyn inni lansio unrhyw gynlluniau peilot, i sicrhau ein bod yn

over. However, I certainly think that we should pursue many of the initiatives that are outlined in this report.

diogelu'r system. Nid ydym am i unrhyw beth fynd o'i le. Fodd bynnag, yr wyf yn credu yn bendant y dylasem fynd ar drywydd llawer o'r mentrau a amlinellir yn yr adroddiad hwn.

[105] **Dafydd Wigley:** I am very grateful to you for that and for your evidence. Clearly, the writing up of a report on this will straddle the election period and it may well be that the new Committee that will be formulated in the new Assembly will want to return to some aspects of this. There may be opportunities for other interests to appear before the Committee, to make sure that there is a proper balance of evidence, before the final report is drawn up. I thank you very much for the comprehensive nature of the replies that you have given. I think that you are going to be staying on for the next item, are you not?

[105] **Dafydd Wigley:** Yr wyf yn ddiolchgar iawn i chi am hynny ac am eich tystiolaeth. Yn amlwg, bydd y gwaith o ysgrifennu adroddiad am hyn yn digwydd y naill ochr i gyfnod yr etholiad ac mae'n bosibl y bydd y Pwyllgor newydd a fydd yn cael ei greu yn y Cynulliad newydd am ddychwelyd at rai agweddau ar hyn. Efallai y bydd cyfleoedd i fuddiannau eraill ymddangos gerbron y Pwyllgor, i sicrhau bod cydbwysedd cywir o dystiolaeth, cyn llunio'r adroddiad terfynol. Diolch yn fawr iawn i chi am natur gynhwysfawr yratebion yr ydych wedi eu rhoi. Credaf eich bod yn mynd i fod yn aros ar gyfer yr eitem nesaf, onid ydych?

Ms Lloyd: Yes, and I have lost my headphones.

Ms Lloyd: Ydw, ac yr wyf wedi colli fy nghlustffonau.

[106] **Dafydd Wigley:** In which case I will stick to English. Before we move on, as I always do, I will explain that the draft transcript will be sent to you in order for you to have an opportunity to correct any factual mistakes before it is published. It will then be published as part of the minutes of this meeting, and will appear as an attachment when we finally bring our report forward. Thanks to both Carolyn and yourself.

[106] **Dafydd Wigley:** Os felly, parhaf yn y Saesneg. Cyn inni symud ymlaen, fel y gwnaf bob tro, hoffwn egluro y bydd y trawsgrifiad drafft yn cael ei anfon atoch er mwyn i chi gael cyfle i gywiro unrhyw gamgymeriadau ffeithiol cyn ei gyhoeddi. Bydd wedyn yn cael ei gyhoeddi fel rhan o gofnodion y cyfarfod hwn, a bydd yn ymddangos fel atodiad pan fyddwn yn cyhoeddi ein hadroddiad yn y pen draw. Diolch i Carolyn ac i chi.

Daeth y sesiwn cymryd tystiolaeth i ben am 10.27 a.m.
The evidence-taking session ended at 10.27 a.m.

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[i] Mae'r pwyllgor contractio cyffuriau Cymru gyfan yn negodi contractau ar gyfer rhyw 500 eitem o'r miloedd o gyffuriau sydd ar gael mewn gofal sylfaenol ac eilaidd.
The all-Wales drugs contracting committee negotiates contracts for some 500 items from the thousands of drugs that are available in primary and secondary care.

[ii] Caiff papur ei gyflwyno i'r grŵp strategaeth meddyginiaethau Cymru gyfan yn ei gyfarfod ym mis Mehefin.
A paper will be presented to the all-Wales medicines strategy group at its June meeting.

British Medical Association
General Practitioners Committee (Wales)

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Mr Frank Grogan
National Audit Office Wales
National Audit Office
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CF10 3DP

Our Ref: ARD/SJE/PPC Medicines

17 June 2003

Dear Mr Grogan

AUDITOR GENERAL FOR WALES' REPORT ON THE PROCUREMENT OF PRIMARY CARE MEDICINES

I enclose a copy of GPC(Wales) response (this response was previously sent to you in April) on the procurement of primary care drugs.

Recognising that you next meet on the 17 July to discuss this document further, I would like to highlight our main concerns:-

- The potential devastating effect several of the suggestions in the paper will have on dispensing practices. As these practices are mainly in rural areas we would be very concerned regarding any suggestion that might reduce the provision of General Practice in these areas. Many of these practices depend on their dispensing income to make them financially viable. The future recruitment and retention of General Practitioners in these areas would be severely affected if dispensing income was significantly reduced, by interfering with dispensing practices' ability to negotiate on price.

- Savings from central purchasing for primary care are likely to have a detrimental effect on dispensing income and may totally destabilise the provision of GMS in rural Wales. These areas already have difficulty in recruiting new GPs and anything that made recruitment and retention more difficult would be most unwelcome from the patients' point of view.

Could I therefore ask in your discussion on this report that you consider the long term consequence to GPs and patient care along with any short term cost savings.

Yours sincerely

SJEllmes

pp

Dr A R Dearden
Chairman, GPC(Wales)

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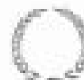

DRAFT RESPONSE ON THE PROCUREMENT OF PRIMARY CARE DRUGS.

GPC Wales are pleased to have the opportunity to comment on the draft Audit Commission paper for the National Assembly on procurement. We are concerned, however, that the report perpetuates a number of misconceptions.

The proposal appears to be that the central purchasing of several drugs for use in primary care should be piloted, although mention is also made of a watching brief on the Department of Health Work on central purchasing in England.

In point 3-11 a suggestion is made that the pharmaceutical industry might wish to demonstrate by equivalent contracts in primary and secondary care that it was not subsidising one sector at the expense of the other. This is, in fact, the concern that we had from the beginning about this process and we suspect that for legitimate commercial reasons, the industry may not in fact be at all keen to do that. We remain concerned that if Wales goes down this route alone separate from England, it will provide a real disincentive to dispensing doctors in Wales, exacerbating the already worrisome problems of recruitment and retention.

Several points are made about the threat of such a scheme to security of supply and we would certainly echo these concerns. The idea of dividing contracts between several suppliers would surely defeat the object of the exercise, as small contracts will be unlikely to attract any greater discount than is currently negotiated. The issue of discount negotiating is, of course, fundamental to the BMA's initial concerns in that a substantial element of the profit that dispensing doctors currently make, is around the additional discounts negotiated below the tariff price on certain drugs. Were this element of profit to be lost it is likely to fundamentally affect the business viability of dispensing for a lot of rural Welsh practices. The issue of the 10.5% on cost mentioned later in the paper, actually does not impact on this fundamental concern to the same extent and in any event is likely to be changed on a UK wide basis rather than locally in Wales, thus not affecting the relative position of dispensing doctors in the two countries, although it should be noted that the higher proportion of dispensing doctors in Wales, compared to England and their distribution in the most difficult to recruit areas, means that any change to the viability of dispensing as a business adjunct is likely to have a disproportionate affect on recruitment in those areas. Proposals to bring in partial central purchasing in fact will provide a substantial disincentive to dispensing doctors to standardize their prescribing habits around such drugs, where alternatives exist given that to do so will substantially negatively affect the profitability of their Practice.

The other fundamental point which we attempted to make in the initial consultations was that comparing discounts negotiated in secondary care, with those possible to negotiate in primary care, was likely to be misleading. The arguments around this are fairly well made in fact in 3.20 where it states that a single prescription secondary care can lead onto 15 repeat prescriptions in primary care. The paper also says that manufacturers may be eager to sell their products to hospitals at a substantial discount, perhaps even below cost, in order to capture a proportion of the primary care market where prices are higher. This encapsulates in a nutshell the argument against expecting similar savings in primary care from central purchasing policy and the point is, indeed, expanded on in 3.21 and 3.22.

Later in the Paper – in 4.12 – there is mention of medicines management and attempts to modify prescribing behaviour. There is a substantial thrust in this direction within the new Contract and certainly the BMA would agree that this was a more rational way of approaching the increasing costs in primary care. There is also sensible discussion in the Paper regarding the wider savings to the NHS of a significant amount of the increased prescribing costs in primary care in terms of prevention of conditions which are extremely expensive to treat at a later stage in secondary care. We are fully in agreement with these arguments and feel that too much emphasis on primary care

prescribing budgets may prove counter productive for these reasons. Having said that, we accept the argument that some primary care prescribing is of drugs of dubious therapeutic value. However, the points made in 4.20 – 4.22 regarding the relative importance of correct drug selection as opposed to generic substitution and reducing ineffective drug prescribing suggests that the main thrust of any attempt to control costs in this area should be around medicines management and education, rather than tinkering with other relatively small sums. Having said that, we see no particular problem with the idea of direct generic substitution – perhaps just for a list of drugs where the highest brand/generic differentials exist as given in one of the appendices. An inclusive list for generic substitution rather than a general promotion of the policy would also avoid problems where generic substitution may be not in the best interest of the patient.

To summarize therefore our principal concerns regarding the Paper are that savings from central purchasing in primary care are unlikely to match proportionately those available in secondary care for all the previously rehearsed reasons, and secondly that insufficient regard is given to the potential destabilising effect of a policy which is likely to have a negative impact on the profitability of dispensing practices in the most hard to recruit areas in Wales particularly if this is a Wales only initiative.

Royal Cymdeithas
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Mrs Janet Davies
Chairman
Audit Committee
The National Assembly for Wales
Cardiff
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7 July 2003

CC Members of the Audit Committee
Mrs Carolyn Poulter, National Assembly for Wales
Miss Carwen Wynne Howells, National Assembly for Wales

Dear Mrs Davies

The Procurement of Primary Care Medicines- A Report by The Auditor General for Wales

The RPSGB has considered the above report. As the regulatory and professional body for pharmacists, the Royal Pharmaceutical Society is not involved in matters relating to the NHS community pharmacy dispensing contract. The Society does, however, have an interest in ensuring that the public has access to a safe and effective pharmacy service.

The recommendations that we are able to support do not relate to procurement. We support the report's recognition of the benefits of better medicines management, standardisation of medication pack size and supplementary prescribing. The Welsh Executive produced a briefing paper for Assembly Members last year on the benefits of original pack dispensing (attached for information).

However, we are concerned that the recommendations of the report relating to procurement could have far reaching consequences for patients in Wales.

These concerns include:

- Timely access to acute medicines
- Continuity of supply
- Equity of service provision across Wales
- Supply of medicines in rural areas
- Cross boarder issues between England and Wales
- Potential risk to secondary care of associated increase in costs

The Welsh Executive could only support the principle of testing the recommendation on direct procurement provided the process take full account of the complexity of the existing model, and that it is linked to the Assembly's review of community pharmacy in Wales in order to ensure that individual communities will continue to benefit from access to pharmaceutical services.

Cont/2

The report itself suggests that "...securing potential savings on this scale in practice is not straightforward and is not guaranteed" and we would question the cost benefit of investment of resources of the NHS Directorate in this area at this time.

We would highlight that there are other means of both controlling and maximising the benefit from drug expenditure for which there is a firm evidence base. These developments, including supplementary prescribing, medicines management and repeat dispensing, utilise the skills of community pharmacists, deliver savings combined with health gain and will underpin the development of the NHS in Wales.

The RPSGB has a depth of knowledge in these areas and looks forward to working with the Welsh Assembly Government on such developments to improve the health of the people of Wales.

Yours sincerely

Catherine O'Brien
Welsh Executive Secretary The Royal Pharmaceutical Society of Great Britain.

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GWEITHGOR CYMRU WELSH EXECUTIVE

MODERNISING PHARMACY IN WALES: THE NEED FOR ORIGINAL PACK DISPENSING

MODERNEIDDIO FFERYLLIAETH YNG NGHYMRU: YR ANGEN AM DDOSBARTHU PECYN GWREIDDIOL

What is original pack dispensing?

Most manufacturers supply tablets and capsules in blister packs for 28 days treatment. This ensures the patient has a clearly labelled, tamper evident package with a patient information leaflet (PIL) expiry date and batch number. But the NHS in Wales wastes valuable resources splitting packs and cutting blisters to meet the, often arbitrary, quantity ordered on a prescription.

Does original pack dispensing benefit patients?

Original pack dispensing (OPD) is convenient for patients. As many as 50% of older people may not be taking their medication as intended. By adopting a more patient centered supply, the individual can monitor their own medicine taking more easily and follow the recommended dose more closely.

Patient safety is improved with OPD by reducing the risk of errors when medication is transferred from one container to another during the dispensing process. Last year over 44 million prescription items were dispensed in Wales. Although pharmacists are inherently careful and accurate by nature of their profession, with an increase in the number of prescriptions to dispense and the volume of medicines available in the average dispensary, any measure to reduce the risk of errors should be considered. OPD also allows the introduction of bar-code technology with the potential to reduce the risk of errors still further.

When foil blister packs are cut they have sharp edges that can cause physical harm. There have been cases of patients swallowing the blister pack. Making the packaging safe is difficult and can destroy the seal around the medicine exposing it to damage such as moisture in the environment. Blister packs are child resistant and demonstrate. evidence of tampering. Supplying in an original pack promotes patient confidence in the high quality of their medication and the information supplied with it.

How does original pack dispensing benefit the NHS?

Benefits to the patient work in tandem with those to the NHS. OPD offers value for money for the NHS whilst reducing the risk of errors and increasing patient safety. It reduces process costs in both primary and secondary care and is essential if automation is to be implemented in Wales. Already in some hospitals patients use their own medication. Monthly packs are given when new medication is needed so there is no need to wait for a 'home supply' when patients leave the ward, no delayed discharge or bed-blocking. Patient movement between care settings will be easier and safer and costs to the NHS as a whole will be minimised.

Beth yw dosbarthu pecyn gwreiddiol?

Mae'r rhan fwyaf o gynhyrchwyr yn cyflenwi tabledi a chapsiwlau mewn pecynnau swigen ar gyfer triniaeth 28 diwrnod. Mae hyn yn sicrhau fod gan y claf becyn sydd wedi'i labelu'n glir ac a fyddai'n dangos.unrhyw ymyrraeth anno, gyda thaflen gwybodaeth claf, dyddiad dod i ben a rhif sypyn. Ond mae'r GIG yng Nghymru yn gwastraffu adnoddau gwerthfawr gan hollti pecynnau a thori pecynnau swigen i ddiwallu'r nifer, mympwyol yn aml, a archebir ar bresgripsiwn.

A yw dosbarthu pecyn gwrreeiddiol o fudd i gleiflon?

Mae dosbarthu pecyn gwreiddiol yn gyfleus i gleifion. Gall cynifer a 50% o'r henoed beidio bod yn cymryd eu meddyginiaeth yn of y bwriad. Drwy fabwysiadu cyflenwad sy'n canoli mwy ar y claf, mae'n haws i'r unigolyn fonitro eu hunain with gymryd meddyginiaeth a dilyn y ddogn a argymhellir yn agosach.

Caiff diogelwch claf ei wella dewy ddosbarthu pecyn gwreiddiol dewy ostwng risg camgymeriadau pan gaiff meddyginiaeth ei throsglwyddo o un cynhwysydd i un arall yn ystod y broses ddosbarthu. Cafodd dros 44 miliwn o eitemau presgripsiwn eu dosbarthu yng Nghymru y llynedd. Er fod fferyllwyr yn reddfol ofalus a chywir yn of natur eu proffesiwn, gyda chynnydd yn nifer y presgripsiynau i'w dosbarthu a'r nifer o feddyginiaethau sydd ar gael yn y fferyllfa gyffredin, dylid ystyried unrhyw fesur i ostwng risg camgymeriadau. Mae dosbarthu pecyn gwreiddiol hefyd yn galluogi cyflwyno technoleg cod-bar gyda'r potensial o ostwng risg camgymeriadau hyd yn oed ymhellach

Mae gan becynnau swigen (foil ochrau minibg pan gant eu torn a gall hynny achosi anaf corfforol. Bu achosion o gleifion yn llyncu'r pecyn swigen. Mae'n anodd gwneud y pecyn yn ddiogel a gall dinistrio'r sel o amgylch y feddyginiaeth olygu difrod megis gwlybaniaeth yn yr amgy[chedd. Nid yw plant yn medru agor pecynnau swigen ac mae'n amlwg os oes rhywun wedi ymyrryd a'r pecyn. Mae.cyfienwi mewn pecyn gwreiddiol yn hybu hyder y claf yn ansawdd uchel eu meddyginiaeth a'r wybodaeth a gyflenwyd gydag ef.

Sut ntae dosbarthu pecyn gnrreiddiol o fudd Pr GIG?

Mae buddion i'r claf yn cyd-fynd gyda rhai i'r GIG.

Mae dosbarthu pecyn gwreiddiol yn cynnig gwerth am arian i'r GIG tra'n gostwng risg camgymeriadau a chynyddu diogelwch cle[fion. Mae'n gostwng costau prosesu mewn gofal sylfaenol a gofal eilaidd ac mae'n hanfodol os yw awtomeiddio i'w weithredu yng Nghymru. Mae cleifion eisoes yn defnyddio eu meddyginiaeth eu hunain mewn rhai ysbytai. Rhoddir pecynnau misol pan fo angen meddyginiaeth newydd fel nad oes angen aros am 'gyflenwad cartref' pan fo cleifion yn gadael y ward, dim gohirio

The Task and Finish Group for Prescribing in Wales recommended the supply of monthly patient packs. Implementing OPD will support rational prescribing in primary care and reduce drug waste, estimated to be over f15 million per year in Wales.

Are there any other benefits?

European Community Directive 92/27 requires that all medicines be supplied with a patient information leaflet and labelled with a batch number and expiry date. Original pack dispensing meets this directive, which was incorporated into UK law in January 1999. Pharmacists are concerned that splitting packs risks possible prosecution and that some patients are denied information they have a right to. Implementing OPD in Wales will ensure compliance with the law and ensure parity with accepted practice elsewhere in Europe.

Summary

Original pack dispensing is convenient for patients. It improves patient safety by reducing the risk of errors and ensuring access to patient information. There are benefits to the NHS in increased efficiency resulting from reductions in drug waste and better use of manpower. It would also bring Wales into line with dispensing practice in Europe. OPD is one of the building blocks for the future development in the NHS and should be implemented as soon as practicable.

rhyddhau o'r ysbyty neu flocio gwelyau. Bydd yn rhwyddach ac yn dry diogel i symud cleifion rhwng gosodiadau gofal a byddir yn gostwng y costau i'r GIG yn ei gyfanrwydd. A rgymhellodd Grwp Tasg a Gorffen Rhagnodi yng Nghymru gyflenwi pecynnau misol i gleifion. Bydd gweithredu dosbarthu pecyn gwreiddiol yn cefnogi rhagnodi rhesymegol mewn gofal sylfaenol a gostwng gwastraff cyffuriau, a amcangyfrifir i fod dros f15 miliwn y flwyddyn yng Nghymru.

A oes unrhyw fanteision eraill?

Mae'n ofyniad gan Gyfeireb 92/27 y Gymuned Ewropeaidd y cyfienwir taften gwybodaeth cleifion gyda phob meddyginiaeth a'u bod yn cael eu labelu gyda rhif sypyn a dyddiad dod i ben. Mae dosbarthu pecyn gwreiddiol yn ateb y gyfeireb hon, a ymgorfforwyd yng nghyfraith y Deyrnas Gyfunol yn lonawr 1999. Mae fferyllwyr yn pryderu fod hollti pecynnau yn codi risg o erlyniad ac nad yw rhai cleifion yn, cael yr wybodaeth y mae ganddynt haw[iddi. Bydd gweithredu dosbarthu pecyn gwreiddiol yng Nghymru yn sicrhau cydymffurfiaeth gyda'r gyfraith ac yn sicrhau cydraddoldeb gydag ymarfer a dderbynnir mewn man arall yn Ewrop.

rynodeb

Mae dosbarthu pecyn gwreiddiol yn gyfleus i gleifion. Mae'n gwella diogelwch cleiflon drwy ostwng risg camgymeriadau a sicrhau mynediad i wybodaeth cleifion. Mae manteision i'r GIG o ran mwy o effeithlonrwydd ohenvydd gostwng gwastraff cyffuriau a gwell defnydd o amser staff. Byddai hefyd yn sicrhau fod Cymru'n cydymffurfio ag ymarfer dosbarthu yn Ewrop. Mae dosbarthu pecyn gwreiddiol yn un o'r blociau adeiladu ar gyfer datblygu'r GIG yn y dyfodol a dylid ei weithredu cyn gynted ag sy'n ymarferol.

References:-

fl *Remedies for Success - a strategy for pharmacy in Wales (a consultation document). September* 2002

¢ *Task and Finish Group for Prescribing in Wales - a report to the Minister for Health and Social Services. March* 2001

/3 *Spoonful of Sugar. Audit Commission.* 2001

¢ *National Service Framework for Older People*

Cyfeiriadau:

¢ *Meddyginioeth or gyfer liwyddiant - strategaeth or gyfer /ferylliaeth yng Nghymru (dogfen ymgynghori). Medl* 2002

(3 Grwp Gorchwyl a Gorffen or Ragnodi yng Nghymru - adroddiad Pr Gweinidog lechyd a Gwasanaethou Cymdeithasol. Mawrth 2001.

fl *Spoonful of Sugar Comisiwn Archwilfo.* 2001

A *Fframwaith gwasonaeth Cenedloethol or gyfer yr Henoed*

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Mrs Janet Davies AM
Chair, Audit Committee
National Assembly for Wales
Cardiff Bay
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8 July 2003

Dear Mrs Davies

Re: Auditor General for Wales Report - Procurement of Primary Care Medicines - Response by Community Pharmacy Wales

In continuation of Mr Parry's letter of 10th June 2003 I have pleasure in enclosing the full response by Community Pharmacy Wales to the Report by the Auditor General for Wales into the Procurement of Primary Care Medicines. I am also making copies available to members of the Audit Committee and the Health Committee which I hope is helpful.

As you will see from our response, there is much in the report with which we agree, our main concern is that some major recommendations which constitute a significant change in Assembly policy on community pharmacy are not at all evidence based.

Community Pharmacy Wales would be most willing to follow up the concerns expressed in this document in any way that the committee finds appropriate.

Yours sincerely

Peter Haydn Jones OBE
Chief Executive

Enclosure: Response by Community Pharmacy Wales

Auditor General for Wales Report
Adroddiad Archwilydd Cyffredinol Cymru

Procurement of Primary Care Medicines
Caffaelliad Meddyginiaethau Gofal Sylfaenol

Response by
Ymateb

Community Pharmacy Wales
Fferylliaeth Gymunedol Cymru

Executive Summary

Community Pharmacy Wales represents the interests of all 712 community pharmacies in Wales who between them employ in the region of 4000 full and parttime staff throughout Wales.

We are taking the, perhaps unusual, step of responding to the National Audit Office through the Assembly, not primarily because we disagree with a few of the recommendations but more because we are concerned with the quality and the accuracy of the report and are particularly concerned that there are fundamental omissions and flaws which produce an overall misleading outcome. The Appendix to our response sets out our analysis in detail. We believe the result of this is that the proposals expose the National Assembly to avoidable risks and challenges.

In many instances, the impact of concerns expressed in the report is diminished through lack of evidence, or lack of clarity in its extrapolation. Some drug pricing mechanisms, which are referred to, are not considered appropriately or accurately.

The processes of consultation were perfunctory and some major players were not consulted at all. This has resulted in gaps of information and evidence. We are also concerned that Assembly Members may believe that the usual extensive consultation, collection and checking of evidence has already taken place, which is not the case on this particular report. .

Community Pharmacy Wales is being both reasonable and responsible in opposing the proposal to pilot central procurement. The proposal to pilot is not evidence-based. It does not identify the processes or the scale of such a pilot. To be meaningful the pilot of central procurement would need to he large and this, in itself, could result in lasting damage, both to the supply chain and the viability of the community pharmacy network throughout Wales. The report is focused on cost saving, not on healthcare provision, and sloes not provide a balanced cost-benefit view of any of the advantages of the appropriate use of medicines.

The report is naive in its expectation of savings from central procurement in primary care and has not fully extrapolated the effect of the **PPRS** and other existing price regulating mechanisms. It has not considered the administration and costs of distribution, or the increased risk of supply problems.

The E50M potential savings from central procurement are unproven.

The report does not account for the £30-40M of stock investment in primary care to meet immediate patient need. Nor does it account for the £40M in the supply chain -which is available for twice-daily supply. The supply chain resource includes some 5000 slow moving items that could be put at risk if the proposals were accepted. These 5000 items are usually specialised and needed for serious illness.

The existing supply network of wholesalers and community pharmacies is a tremendous resource that provides a high level of satisfaction and meets real patient needs. It should not be tampered with lightly. Patients would blame the National Assembly for supply problems and the Assembly would have to accept the investment
risk currently absorbed by primary care contractors.

The Department of Health has recognised that community pharmacists need some retained discount as well as remuneration to run the service. Central procurement would substantially reduce this necessary retained discount and community pharmacies as local businesses would become unviable unless other funds were provided.

The report correctly refers to the increase in the drug bill. This comes from the introduction of new medicines and increased demand for them. Central procurement will not change this. Costs are best kept down through good buying by individual pharmacies where there is an incentive, and recovered through government discount enquiries. Central procurement would remove the incentive for individual pharmacists to buy well.

We support the proposals to make better use of pharmacists in the use of medicines. Greater cost benefits are to be found in developing therapeutic substitution by way of supplementary prescribing and through extending medicines management to primary care via community pharmacies.

In this section of the report, the assessment of the £46M potential saving is credible and as it is based on evidence, it would be a supportable approach which Community Pharmacy Wales would support. It is unfortunate that this standard is not maintained throughout the bulk of the report.

Introduction

The Auditor-General for Wales published a report entitled "The Procurement of Primary Care Medicines" on March 20th 2003. The Audit Committee of the National Assembly first considered it on 27th March 2003. The response of the Audit Committee is under preparation.

This document is the response of Community Pharmacy Wales.

Community Pharmacy Wales is the body that represents the interests of all 712 community pharmacies in the health and social care sectors within Wales. Within these community pharmacies there are in the region of 4000 full and part time staff employed throughout Wales. We seek to improve existing activity and develop innovative new services, in a sustainable environment, with the National Assembly and the Welsh Assembly Government

Quality

From the outset, Community Pharmacy Wales must raise our overall concerns with the quality of the report.

We know that the National Assembly relies on good information from the National Audit Office Wales to support its decisions. It may be seen, from our analysis of the report detailed in the Appendix to this document that we have many issues with the accuracy of the information provided, with its interpretation and presentation; ranging from relatively minor issues right up to major fundamental flaws.

We are certain that this is not what is expected of the Auditor-General for Wales' service. Of particular concern to us is that as a result of the National Assembly's reliance on the National Audit Office for information, there might be a tendency to accept the Auditor-General's proposals without proper input from other parties with information of value. If this is the case, the National Assembly will be exposing itself to the avoidable risks we identify.

We are also concerned that the recommendations of the NAO are in such sharp contrast to the agreed policies of the National Assembly on the role and activities of community pharmacy. These policies have been developed through wide and lengthy consultation over more than a year and are reflected in "Remedies for Success" and reiterated in. the robust response by the Assembly Minister for Health in March 2003 to the Office of Fair Trading report attacking community pharmacy. Are we to take it that the NAO proposals can over rule this policy development of the National Assembly? If this is the case, it is also far from clear to us what role the Assembly's Health and Social Services Committee will play in what will effectively be a change of policy.

The report throughout expresses concerns about many potential downsides to central procurement, and is correct to be concerned. However, in missing many of the major issues or through not extrapolating evidence properly, the report's concerns are diminished and do not reflect reality.

The report also provides some evidence, notably the working of the PPRS scheme in its Appendix 3, which might be taken to mean that the PPRS was considered. However, its actual impact does not seem to have contributed in any meaningful way to the thinking behind the conclusions and proposals.

Process

We also have major concerns regarding weaknesses in the process of consultation, analysis of information gathered and consequent development of proposals.

Our first concern relates to consultation with Community Pharmacy Wales. This took the form of a single one and a half hour meeting between two officers of the National Audit Office Wales; and the chairman, financial executive and secretary of our organisation. There was no provision of evidence or movement of documentation between the two bodies. We were allowed to see the document in confidence very shortly before publication but only to confirm the specific sections attributed to us. We were told that the substantive report would not be altered.

In addition, we note that no consultation appears to have been undertaken with bodies or organisations involved in the supply chain. We find this incredible considering the fact that distribution would be central to many of the reports findings - and particularly where the report naively suggests the wholesalers might like to do the distribution for the NHS. This is, no doubt, why the organisation and costs of distribution are absent from the report

To our mind this does not constitute serious consultation - or evidence gathering. The report is deficient and flawed as a result and does a disservice to the high standards that have been set up to now by National Assembly and its Members

We are concerned about the process, which arrived at the recommendation for a pilot. This proposal creates for us a problem of presentation, as it may appear unreasonable for Community Pharmacy Wales to oppose a pilot. However, it is both reasonable and responsible of us to inform the Assembly if we believe that a pilot would hold its own significant dangers.

There was nothing of any substance within the report that supports a pilot. Of most concern is that there is no identified process for a pilot, and no identified scale. A small pilot will not demonstrate the effectiveness of central procurement as it will not have all of the administration and distribution costs attached and would not invoke the drug pricing feedback mechanisms. A small-scale pilot would not be useful. A largescale pilot, even with a selection of medicines, would of itself severely damage the supply chain and reduce the viability of existing pharmacy businesses. We are surprised that such recommendation can be made without proper impact assessment. We are also unclear how this process can be in compliance with the Assembly's statutory duty to consult with business.

We are also surprised that the Auditor-General should choose to expose the Assembly to the expense of piloting a proposal that has no evidence to support it, when there are other options such as medicines management which have a proven track record - and which should be introduced as a community pharmacy service.

Main Issues

We intend to focus on the main and fundamental flaws in the document. However, we would commend the reading of the Appendix to this document, which provides a full analysis of the report

Importance of Quality and Cost

The report has a predominantly cost saving focus. This is understandable as the NHS primary care medicines bill is a large and growing budget. It is, however, important to recognise that medicines intelligently used are capable of improving the quality of life for patients, and their families. Their appropriate use can result in savings in secondary and tertiary care - and greater independence which has a benefit for social care budgets.

Medicine Pricing Mechanisms

The report compares the cost of drugs in primary care with prices available to the All Wales Contracting Committee (AWCC), purchasing for hospital departments. There is only tacit recognition of the loss-leading environment - which heavily influences prescribing in primary care. There is naive expectation that pharmaceutical companies might provide the same discount for primary care medicines that they provide for secondary care. It simply will not happen. There is no reason for them to do this.

The report in its Appendix 3 outlined the working of the PPRS. The PPRS is a mechanism agreed between Government and the pharmaceutical industry to protect investment and research into new medicines by protecting their revenues. And so, even if the discounts offered to secondary care were provided for primary care central procurement, the manufacturers would increase the base price - and there would be no net gain. Rather there would be a leveling of prices resulting in a small decrease in prices for primary c are and a large increase in secondary c are in order t o preserve overall sales revenue of the manufacturers.

To compound this, there has been no consideration within the report of the cost of distribution. This factor, added to the medicines pricing mechanisms, could risk the NHS expenditure on medicines increasing rather than decreasing.

The expected E50m saving envisaged from changes to procurement is unproved.

Meeting Patient Expectation

Patients expect, and more importantly need, medicines to be provided promptly. This requirement is built into the NHS Terms of Service for pharmacies. The report has not analysed either the risks to the NHS or the scale of the medicines resource offered by pharmacies and the supply chain. As far as stockholding is concerned there is between £30M and £40M of stock in primary care practices. This, in the main, represents the 90% or so of faster moving products. In addition, there is a further E40M of stock sitting in the supply chain, available on a twice-daily delivery

system - with courier backup for emergency items. Much of that stock is for replenishment of the 90% faster moving lines but it also includes a tail of about 5000 lines, which are slower moving. These 5000 lines are often the more specialised products needed for serious illness.

That is a tremendous resource for the people of Wales. It provides a very high level of satisfaction and meets real needs. It is not a resource to be lightly tampered with. It is also a service which has serious costs attached to it and a need for profitability to work effectively.

The supply chain and primary care practices absorb all the risk of stockholding and meeting patient expectation, which would fall to the National Assembly if central procurement were implemented or piloted. Certainly, if the pilot drew away the more commonly used and expensive items - as hinted in the report - it would have a damaging effect on the ability of the supply chain to provide the 5000 slower moving items. The National Assembly would be directly blamed for any supply problems and for lack of reproducibility of brand or generic products.

Patients groups in Wales and throughout the UK are increasingly a source of expertise and an active self-management resource. However, the tone of the debate on the report has been unfortunate in that it assumes the majority of patients to be irresponsible in their use of medicines. Again, reality is at odds with the implicit assumptions of this NAO report.

Required discount for viability

Pharmacists receive discount from their suppliers. In principle, pharmacies are not supposed to make a profit on medicines supplied and so the Government operates discount enquiries to set a scale so as to claw back discount. That way it benefits from the good purchasing activity of community pharmacists - who attempt to beat the discount and prices set by the Drug Tariff. The Department of Health has recently, in correspondence with the Pharmaceutical Services Negotiating Committee, stated that there is insufficient funding in the remuneration of pharmacies to operate the service. It has acknowledged that, within the current contract model, some income for pharmacies is needed from retained discount.

Central procurement would remove a large portion of this discount, and pressure on supplier profitability would reduce remaining discount from the other lines. By the Department of Health's own admission this would seriously affect the viability of community pharmacies.

Reality on Drug Pricing and Discount

The £50M saving hoped for will not happen. The increase in the drug bill is driven by the introduction of new medicines and by patient demand for them - not by rising prices. The positive outcomes from the introduction of new medicines have been dealt with earlier. The activity of the 700 plus community pharmacists benefits the NHS Wales drugs bill in that as they seek better discount through good buying, the NHS chases its claw back through discount enquiries. This mechanism would be lost if central procurement was introduced, as the incentive would be lost; with a resultant acceleration of drug costs to NHS Wales.

Supported findings and proposals

There is one section of the report where we agree that substantial savings can be achieved. That is through greater use of community pharmacy skills. We stated earlier that intelligent and appropriate use of medicines was of greater importance than simple cost. Community pharmacists are well placed to directly realise the f15.6M savings from better medicine use by patients. We are also able to support GPs and others to achieve the £30AM through prescribing support initiatives. Community Pharmacy Wales would welcome discussion with the National Assembly and Welsh Assembly Government officials over the following series of practical measures which are within the strategy of the Assembly's community pharmacy policy "Remedies for Success".

Original Pack Dispensing

We believe it improves the quality of care, improves compliance and improves patient safety for medicines to be provided in sealed original packs with patient information leaflets. These leaflets reinforce the verbal counseling provided by pharmacists.

Generic substitution

There is a high level of generic prescribing in Wales already and there are many mechanisms in place to encourage it. There may be some further savings to be made here - where pharmacists make decisions to substitute appropriate generic products for branded products. It would not need central procurement as a prerequisite. However, prescribers may feel that their therapeutic freedom is compromised by such an approach.

Therapeutic Substitution

At first sight this might appear to be of greater concern to prescribers in terms of their therapeutic freedom. But if looked at in the context of supplementary prescribing, where the GP and the Community Pharmacist with the patient's consent devise an agreed care plan, there should be little concern. The benefit lies in better targeting of medicines to improve compliance and reduce waste; and in enabling faster response to change in patient condition - reducing the impact on primary care and the multiplied cost of secondary care.

Appendix A to CPW
Response to Auditor General for Wales Report

Analysis of NAO Wales Report
Procurement of Primary Care Medicines

Part 1: Introduction

Primary care medicine procurement is a significant element of healthcare expenditure

Section is factual information. Only item of dispute is section 1.3 where secondary care review has not been referenced

Part 2: Overall audit review of primary care medicine procurement arrangements

2.1 No challenge

Primary care medicine procurement is a complex mixture of market forces, government **regulation *and government-industry agreement***

2.2 No challenge

2.3 Government should have been included in the diagram as through the PPRS scheme for branded medicines and Maximum Price Scheme for generics the government has in place controls, which act as a negative feedback mechanism.

Price setting arid agreements

2.4 Mentions the PPRS and MP schemes but does not explain the mechanism by which they work. This is a major omission as the PPRS and enquiries by the DoH provide negative feedback mechanisms, which adjust prices and profitability from medicines. These mechanisms would negate the proposals in the report.

2.5 Does not bring out the fact that while the Drug Tariff is a document published for England and Wales, there are differences in the availability of medicines under the Drug Tariff in Wales by comparison with England from time to time and differences in how they are provided.

There is often a delay in the availability of medicines in special categories and for the blacklisting of some medicines due to the NAfW having to sign off the changes

The prescribing and dispensing of medicines for people involved in substance misuses allows any Controlled Drug medicine for a misuser to be written by instalments in Wales which is not the case in England.

Purchasing

2.6 Agree with the issues in this paragraph. The activity and stockholding of pharmacies offers a considerable resource to the NHS in Wales both in terms of

availability of medicines and minimising the NHS exposure to risk and administrative burden. The section has not examined the value of the stock in pharmacies, which is an omission in that the NAfW are not appraised of the financial risks they may be seeking to undertake. Nor has it addressed the amount of stock wholesale suppliers and distributors have available.

The average stockholding of a pharmacy is between £30K and £40K and on the basis that dispensing GPs have similar figures this represents a £30m to £40m resource for immediate supply to patients by primary-care practitioners. This resource would need to be replicated by NHS Wales with the attendant risks for the NHS. The risk is currently spread over the 1000 plus contractors.

In addition, figures we have received inform us that in addition to the medicines resource held by community pharmacies and dispensing doctors, there is £40m of medical stock in the supply chain for distribution to Wales on a twice daily delivery system. Wholesalers carry some 12,000 product lines, with 2,700 of these producing 90% of sales, which in the main represent the ready stock within pharmacies. 5,000 lines give 2% of sales with a stock investment of £13M. This slower tail of products is important to the patient, and wholesalers would be unable to offer them or provide discount terms if they were not distributing the full range of products.

The NAfW needs to be appraised of the magnitude of risk they are taking on both in financial terms and in terms of patient access to medicines. They would be taking on all the risks associated with shortages, delivery failures and would be blamed for any outcome which involved patients not being able to get necessary medicines at the right time

Reimbursement

2.7 The discount enquiries are used by the DoH to adjust the discount claw back scale to reflect the changing environment of drug prices. Contractors attempt to beat the fixed price system and the current discount scale to make a margin. The DoH chases this down using discount enquiries and as a result benefits from lower prices for medicines through pharmacists good buying. If the system was perfect and pharmacists were reimbursed at exactly the purchase price, there would be no incentive to buy well, discount would disappear and prices would rise. Central procurement would have this effect.

2.8 is factually correct. However it misses out on recent discussion between PSNC and the DoH who have recognised that the remuneration (Global Sum) system is insufficient to support the community pharmacy service. There is recognition by the DoH that the retained profit from beating the fixed price and discount arrangements on medicines are an essential part of maintaining the service. Central procurement would erode this and there would be a need for an increase in the fees etc within the remuneration side if central procurement were introduced which would negate the desire to reduce costs to the NHS.

Exceptions

2.9 F actual information but they have assumed that Oxygen is only supplied direct through centralised contracts. In fact only oxygen concentrators are paid for in this way. Oxygen as a medicine in cylinders is supplied on prescription and reimbursed within the normal processes. Oxygen support services are paid for by LHBs from the community pharmacy global sum.

Primary care medicine procurement arrangements in Wales are similar to those in other parts of the UK

2.10 Agreed but to note the comments made earlier about differences in fact, between the Drug Tariff for Wales compared to that for England.

2.11 No challenge

Secondary care medicine procurement arrangements unify NHS buying power

2.12 Process described is correct but it does not illuminate the environment in which this works. The pharmaceutical companies, within constraints, are very keen to heavily discount products to secondary care in the knowledge that the proportionally small secondary care market heavily influences prescribing in the much larger primary care market. Within that "loss leader" environment, with the enthusiasm of pharmaceutical companies, it is very easy to maximise savings.

2.13 Paints a gloomier picture for primary care than is actually the case. The information in primary care is not as coherent but there is a great deal of very good data within Health Solutions Wales about the cost and volume of individual medicines which is provided as PARC analysis for LHBs and for clinicians. This data is used to support initiatives to control the cost effectiveness, and quality, of prescribing in primary care. This mirrors the processes available in secondary care.

The National Assembly for Wales has some powers to change primary care procurement arrangements

2.14 - 2.17 No challenge

Part 3: Primary care medicine procurement arrangements may offer scope for reducing costs

3.1 Is a scene setting paragraph

The NHS Wales obtains medicines at much the same price as NHS Scotland and the NHS in Northern Ireland

3.2 to 3.5 No challenge

NHS Wales, like the NHS in other parts of the UK, pays more for the same medicines it procures for primary care than those it procures for secondary care

3.6 Assumption is that the same prices are available in primary care as achieved in secondary care through central tendering. This simple assumption lies at the root of the inadequacy of this document. Clearly, manufacturers have to make a reasonable margin - which is why we have the PPRS. If manufacturers were forced to provide the same level of discount to primary and secondary care, the PPRS mechanism would come into play and increase the base price of drugs to compensate.

3.7 The 50% reduction in prices is not what one would actually achieve. Rather than a drop in prices a levelling would be the outcome. The levelling out would produce a relatively small drop in primary care prices and a very large increase i n secondary care prices. The overall outcome would be very little change, any small savings being offset by distribution costs, which have not been addressed. This is a fundamental flaw in the report. Also the fact that relatively few medicines used in primary care are procured by the All Wales Drug Contracting Committee suggests it is not an appropriate model for primary care.

3.8 The £50m potential saving is a fiction derived from the poor analysis of the marketplace and government mechanisms in the preceding paragraphs. The suggestion that a small number of products accounted for a large amount of saving raises concerns about cherry-picking. These products, by volume, account for a large proportion of the medicines distributed and would require a distribution system on a similar scale. The combination of that volume and their cost represents a large part of the retained discount received by pharmacies which the DoH have recognised is required to maintain the pharmacy service. It would also remove from the distribution chain those bread and butter lines, which make distribution worthwhile. Their removal would result in further loss of offered discount - endangering pharmacies further - and / or loss of distribution of the 5000 slow moving lines, for which the NAfW would be held responsible.

3.9 Generic substitution can be achieved with or without central procurement.

3.10 We do not wish to comment on this paragraph

3.11 Starting only with the items covered by the AWDCC would strip out of the system the lines we have identified above with the consequent outcomes.

3.12 to 3.14 These paragraphs are not core issues but merely illustrate the complexity of generic medicines being introduced.

Achieving savings from centralised procurement would not be straightforward for Wales acting alone

3.15 Agreed.

Centralisation increases risk to security of supply

3.16 No challenge

3.17 We agree with the first part, which reflects our view of the £30 - 40m stock in pharmacies and dispensing GPs. The solution of using the existing supply networks as much as possible is a little precious. It does not appear that there has been any investigation of whether the wholesalers would be prepared to distribute lines they formerly supplied. Our information is that if they lose the mainstream products they would not be able to distribute the remaining products either at the same discount, or at all for the slow moving tail of lines.

3.18 The threat to supply from customers paying higher prices is very real as most of the suppliers for Wales are based outside the area and would give preference to English contractors. Dividing supply between several contracts would mean less consistency of supply of product, which concerns patients and will add to workload in the pharmacy

3.19 Parallel trading would obviously develop, reducing manufacturer revenues from other areas of the UK. The PPRS would then adjust the base price as indicated earlier and prices would rise to compensate. It could also lead to shortages as stated.

3.20 The AWDCC only has a portfolio of about 500 primary care medicines in a much smaller market. The solutions they have come up with to maintain security of supply are unlikely to be robust in the new environment.

Low prices may be harder to negotiate for primary care than secondary care

3.21 and 3.22 raise the concerns that we had earlier about the fact that the drivers to provide medicines at low prices in secondary care are very different to those which would apply in primary care

Achieving low prices for primary care medicines may lead to higher prices for secondary care medicines

3.23 The concerns in this paragraph need to be expressed more strongly. For all the reasons we have given above the cross subsidy will disappear and prices will rise substantially as a direct result and again separately as the PPRS adjusts prices to maintain revenue for pharmaceutical companies.

The achievement of low prices will be limited by the expertise and effort NHS Wales can devote to negotiating contracts

3.24 The resource implications for NHS Wales would be considerable and would mirror those already in the supply chain with similar costs. Including comparisons with other EU countries would add to the burden. It beggars belief that in a competitive world market Wales would have the clout, by comparison with Germany or France, to establish with a manufacturer, `most favoured nation' status for ensuring supply of their product. The report does not provide any evidence to support this possibility

3.25 Limiting the number of items would still have a devastating effect on the supply chain and would make the *NAM* responsible for shortages or non-supply as a direct result.

Centralisation would require changes to the contracts of primary care contractors and may require primary legislation

3.26 Agree the content of this paragraph but add that we are not confident that the NAfW has the manpower to negotiate a new contract with pharmacy at this time.

3.27 Using incentives increases the cost of the medicines centrally procured. Using an "approved" list removes the clinical freedom of the prescriber.

Overall there is scope for savings from NHS Wales undertaking centralised procurement, but this is accompanied by risks and practical challenges

3.28 We would argue that there would be no savings from central procurement, and that if distribution and administrative costs are added in we might see increased costs. The report did not give evidence of how distribution and administration would be provided and at what cost. Centralisation of procurement is not appropriate even under the present arrangements. If the DoH makes changes following their review, the viability might change but would need examining afresh.

The NAfW needs to be very aware of the fact that pilots will be either too small to demonstrate the results they are seeking, or they will be large enough to demonstrate but have the effect of destroying the huge medicines resource in the existing supply chain. Changes in the necessary retained discount for pharmacies would need to be redressed (which means a new contract) or will destabilise pharmacy services to patients.

Part 4: Wider considerations for primary care medicine procurement

4.1 No challenge

The Department of Health has a review of procurement arrangements underway that could have implications for Wales

4.2 and 4.3 are descriptive paragraphs

4.4 Recommendation reiterates that covered under 3.28. The *NAM* should not delay. It should reject the proposals contained in this report as lacking robust evidence and consideration for the full arena of procurement.

The Assembly will need to assess how changes in procurement arrangements may affect wider pharmacy and medical services

4.5 The report is correct to allude to other developments such as the OFT report. The effect on access by patients would be cumulative

The Assembly's Pharmacy Strategy needs to take account of possible changes to procurement arrangements

4.6 No challenge

Changes to procurement arrangements could affect access to community pharmacies

4.7 No challenge

4.8 This is the same recommendation that came out of the OFT report. It does not recognise the lifeline nature of the ESPS and that increasing its scope would add to costs thereby negating the savings envisaged.

Changing procurement arrangements could also affect GP services in rural areas

4.9 and 4.10 These paragraphs should be addressed by GPC Wales on behalf of GPs. We do not wish to interfere in GP issues other than to say that we believe the issues over stock holding, distribution etc would be damaging in a broadly similar way.

Changes to procurement arrangements could adversely affect distribution networks

4.11 The recommendation implied in the last sentence is a total inconsistency. The Assembly will not be able to provide savings in a way that will not affect wholesaler's margins and revenue

The Assembly should consider the possible impact of changes to procurement on wider pharmaceutical industry involvement in research and development of new treatments

4.12 and 4.13 We wonder if the response to concerns about R&D into new treatments is being taken seriously enough by the report.

The Assembly should continue to keep in view the importance of prescribing behaviour and medicines management

4.14 We would recommend that the NAM look to develop a more direct day to day role for community pharmacy in supporting neighbouring practices hone their prescribing skills and through medicines management

Changes in prescribing behaviour have led to increased expenditure on medicines

4.15 No challenge

4.16 No challenge to the paragraph. It should be borne in mind that newer better treatments and medicines mean that patients can be treated at home reducing pressures on secondary care costs and waiting times. If there had not been an increase in medicines costs there would undoubtedly have been a greater cost of secondary care. In this context the increased medicines expenditure should be seen as worthwhile.

4.17 No challenge

4.18 Paragraph supports the point raised in 4.16

Despite good reasons for increasing expenditure on medicines, there is scope for savings

4.19 to 4.25 No challenge

The Assembly's NHS Directorate supports initiatives to improve prescribing behaviour

4.26 No challenge

4.27 No challenge

Savings could be achieved through generic substitution

4.28 and 4.29 No challenge

4.30 We support the views on supplementary prescribing as a route to therapeutic substitution particularly as it would reflect GP sensitivities to changes to their prescribing by being part of a Care Management Plan

4.31 W a are delighted with this recommendation and are confident that the NAf W
will be aware of the need for this to be adequately rewarded. A constraint may be
manpower in some areas but we look forward to working out solutions to this.

Savings may also be achieved through better primary care medicines management

4.32 We agree the £15.6m scale of losses through wastage

4.33 Agreed

4.34 Agree with the original pack dispensing (OPD) proposals. OPD does not necessarily, of itself, reduce the number of lines - it only recognises the dispensing of complete packs.

4.35 We welcome the part of the recommendation, which supports the preceding paragraphs in support of a role for community pharmacy in medicines management. However, for the reasons we set out in our argument with the earlier parts of the report, we need to be cautious about the need to link it to procurement arrangements. Medicines management does not need a change to procurement arrangement to work well. Again we are hopeful that the NAf W would seek to adequately reward community pharmacy for this activity.

Appendix l: Methods of examination

The methods of examination were somewhat lacking.

On the issues side it did not take into account fully:

- the mechanisms which feedback and negate the savings desired,
- the effect such changes might have on prices in other parts of the UK, nor
- the views of the industry and the supply chain of such changes and how they would react

As for technique we are concerned at the naivety of using the AWDCC figures and their extrapolation to primary care. We believe this reflects the missing issues above and the poor consultation.

Appendix 2: Organisations consulted by the National Audit Office Wales

Consultation with Community Pharmacy Wales amounted to a short discussion of the issues and an opportunity to agree the points we had raised just prior to release.

We note there was no consultation with wholesalers or their organisations, which is a gross error when considering central procurement and may be why they have not addressed distribution and administration costs.

Appendix 3: Description of existing primary care medicine procurement arrangements

It is unfortunate that having presented the PPRS information to show that the report considers it, that the content of this paragraph 1 has not formed a part of thinking

Appendix 4: Initiatives to support improvements in prescribing behaviour

Factual

Appendix 5: Generic substitution and the savings that could have resulted in 2001

Factual

Medicines management

Many studies have proved the benefits of better medicines management and pharmaceutical care. It is often quoted that for every £1 spent on medicines management there is an ultimate saving of £8. The process brings together the patient and health professionals into a synergistic relationship where all parties benefit. The report "A Spoonful of Sugar" has made medicines management a requirement in secondary care. We think it should be extended to primary care via community pharmacy. This approach is specifically supported in the National Assembly policy document Remedies for Success and we wholeheartedly commend it.

Conclusion

We hope that our analysis of the Auditor-General for Wales report has been helpful in setting out the concerns and dangers in the proposals around central procurement. We further hope that the National Assembly will accept our view that implementation of many of the report's recommendations represents a significant risk to the continued existence of a system which works extremely well; and a significant risk to the Assembly in terms of potential cost and public dissatisfaction. We hope that the National Assembly's Audit Committee will support our call to reject the proposals for central procurement in the primary care sector.

We also hope that the Audit Committee will support the proposals contained in the report for original pack dispensing and which seek to use community pharmacists skills better, which are also set out in Remedies for Success - the Welsh Assembly Government's consultation on a plan for pharmacy in Wales

Community Pharmacy Wales is committed to seeking ways of improving patients' experiences of healthcare and the NHS, in partnership with others.

REPORT BY THE AUDITOR-GENERAL FOR WALES: "THE PROCUREMENT OF PRIMARY CARE MEDICINES"

RESPONSE BY THE ABPI CYMRU WALES INDUSTRY GROUP

EXECUTIVE SUMMARY

This paper is the response of the ABPI Cymru Wales Industry Group (WIG) and the Association of the British Pharmaceutical Industry (ABPI) to the report of the AuditorGeneral for Wales on "The Procurement of Primary Care Medicines".

We have a number of fundamental concerns about the report. We believe that:

- The approach of the report is driven by a narrow concern to achieve short-term savings in medicines procurement without fully understanding the broader implications of introducing major changes to the current system or, indeed, the value of medicines.

- Medicines are not just another consumer product, but are essential to the health and well-being of people in Wales and are the result of intense research and development, worth more than £3.2 billion each year in the UK alone. The need to secure continued investment of this scale is one of the reasons why the UK Government and the pharmaceutical industry have agreed to the Pharmaceutical Price Regulation Scheme (PPRS). This report represents a significant challenge to the integrity of the PPRS and hence threatens to undermine the research and development capacity of the pharmaceutical industry with important consequences in terms of the economy and the fight against chronic disease.

- The report fails to put the increasing expenditure on medicines in its proper context: the increased emphasis on preventing disease by investment in primary care and the increasing standards of care prescribed as a result of health policy developments such as National Service Frameworks.

- The report's assumption that cost-savings achieved in secondary care by central purchasing can be replicated in primary care represents a fundamental misunderstanding of the way in which the market in pharmaceuticals operates and the principles which underpin the PPRS.

- Centralised purchasing for primary care on any significant scale is incompatible with the current systems of reimbursing community pharmacists and prescribing GPs. It risks under-mining the commercial viability of community pharmacies, particularly in rural areas.

- Although the industry supports appropriate generic prescribing, the Report's advocacy of generic and therapeutic substitution risks undermining the relationship between doctor and patient. We strongly oppose therapeutic substitution, which challenges the accountability of the doctor for their patient's treatment

We would welcome the opportunity, should the National Assembly's Audit Committee return to this subject, to present evidence to the Committee along with other relevant bodies such as Community Pharmacy Wales and the BMA.

Introduction

On 20 March 2003 the Auditor-General for Wales published a report "The Procurement of Primary Care Medicines", which was considered for the first time at the National Assembly for Wales' Audit Committee on 27 March.

This paper is the response of the ABPI Cymru Wales Industry Group (WIG), and the Association of the British Pharmaceutical Industry (ABPI) to the report.

The ABPI represents the pharmaceutical industry in the UK, including those companies responsible for the research and development and manufacturing of branded products. The ABPI Cymru Wales Industry Group (WIG) brings together members of the ABPI with a particular interest in, and focus on, Wales, and currently consists of 28 members, ranging from major multi-nationals to smaller Welsh-based companies.

In this response, we firstly present some general remarks, which seek to put the AuditorGeneral's report in the broader context of the role of medicines in the provision of health care in the UK; we then present some specific responses to the Recommendations made in the report; and finally, we put forward some proposals on the next steps in the process of considering the report within the National Assembly.

Overview

We welcome the interest of the Auditor-General in the issue of the procurement of primarycare medicines, and share the belief that underpins the report that it is essential to ensure best value for the nation's health in terms of medicines management

A cost-driven approach?

The Auditor-General recognises at the outset that the procurement of medicines is "shaped by a complex mixture of market forces, scientific developments, government regulation and agreements between government and industry" (Executive Summary para. 1). He also throughout the report draws attention to the potential negative impacts of his recommendations. We echo his concerns and believe that the report is driven principally by a narrow concern to achieve short-term savings in medicines procurement without fully understanding the broader implications of introducing major changes to the current system or, indeed, the value, rather than the cost of medicines in general.

We fear that, like the recent Office of Fair Trading Report on "The Control of Entry Regulations and Pharmacy Services in the UK" (which the Welsh Assembly Government together with the other devolved administrations has essentially rejected), this report pays

too little attention to the potential for major damage being done to the health care system by a purely cost-driven approach to the provision of health care.

*Putting **investment at risk***

We believe it is essential that any discussion of the pricing and procurement of medicines takes into account the broader context of the impact of any changes on long term health and well-being of patients in Wales and the rest of the UK

In particular, it is critical to remember that medicines are not just another consumer product, but are essential for the health and well-being of people in Wales and are the result of intense research and development. The pharmaceutical industry invests more than L3.2 billion each year in the UK in the research and development of new medicines to improve the health and quality of life of people in the UK and throughout the world (and directly employs some 70,000 people in so doing): research units within Wales are now opening and more are under development. The need to secure continued investment of this scale is one of the fundamental reasons why the UK Government and the pharmaceutical industry have agreed to the Pharmaceutical Price Regulation Scheme (PPRS) for almost the last 50 years.

The PPRS secures the provision of safe and effective medicines for the NHS at reasonable prices and promotes a strong and profitable pharmaceutical industry capable of such sustained research and development expenditure as should lead to the future availability of new and improved medicines. It effectively places a ceiling on profits, thus protecting the National Health Service from "excessive" prices. The scheme was introduced in 1957 and for nearly 50 years has played a major role in securing the stability of pharmaceutical pricing in the UK, while recognising the unique nature of the NHS as a virtual single purchaser of the industry's products.

Any policy changes, such as central purchasing of primary care medicines, which undermine the PPRS must be examined from the perspective of their potential impact on research and development, and hence both jobs and investment in the UK economy, and the development of new treatments to alleviate the major sources of ill-health in Wales and the rest of the UK.

While the Auditor-General's report refers to these concerns (paras. 4.1, 4.12-13), their relevance seems to have been largely ignored and they do not appear to have influenced the overall consideration of the subject. The suggestion that this absolutely critical issue can be adequately addressed by simply involving "the industry's representatives in Wales in considering such changes" (welcome though the dialogue between NHS Wales and the industry is) reveals a lack of real understanding of the fact that the pharmaceutical industry is not operating in a free market, and that the finely-balanced regulatory system which exists today has been built up to provide value for money for the NHS with the need to secure investment in the UK and globally on research.

In this context, we would also like to correct an apparent perception by some members of the Assembly's Audit Committee that the market in Wales is sufficiently small that novel arrangements, which threaten the status quo, would somehow be below the "radar" of the industry. The ABPI Cymru Wales Industry Group was set up in response to the new policy environment created by devolution, and we have embraced the opportunity to work in partnership with the Welsh Assembly Government, the National Assembly and NHS Wales. In addition the ABPI has further confirmed its commitment to Wales by establishing a national office in Cardiff. We recognise and support the opportunities for policy innovation in Wales whilst appreciating that given the current UK-wide regulatory framework, changes which undermine the PPRS in one part of the UK risk destabilising the operating environment for the industry *throughout the* UK thereby jeopardising long-term investment in research. The UK Government established the pharmaceutical Industry Competitiveness Task Force in 2000 (which involved officials from the Welsh Assembly Government) and this stressed "the importance of ensuring that proposed changes to the pharmaceutical regulatory environment are considered very carefully in terms of their potential to impact on the UK-based industry. New policy changes should not be viewed in isolation but as part of the overall environment". This, we believe, must apply to all parts of the UK.

The "cost" of primary care medicines

The Report lays much stress at the very start of the report on the increasing cost of the total medicines bill in Wales (para. 1.1). It is only on page 19, that it is explained that the cost of *individual medicines* has been falling (indeed, average prices are 12% lower than 10 years ago) and that the budgetary increases are due principally to improved access to new and existing medicines, thanks to scientific developments and the impact of policy changes such as the National Institute of Clinical Excellence and the introduction of National Service Frameworks. We would like to emphasise that expenditure on medicines in primary care is not simply a *cost* to the NHS: it can reduce the demands on far more costly secondary care interventions (for example, wider use of statins has been shown to reduce the incidence of heart-attacks and the need for heart by-pass operations), as well as saving and improving the quality of individual patients' lives. This has been recognised, in England, by the Secretary of State for Health who, speaking at the ABPI Annual Dinner in April this year, stressed

"I said three years ago that more spending on medicines is, in my view, a good thing, not a bad thing. . . over time I would expect to see the importance of medicines to the NHS continuing to grow. And in all likelihood drugs spending as a proportion of NHS spending will also continue to grow. Too much of the debate on health care today in my view is still focused on the narrow terrain of hospital based activity… changes in demography and the pattern of illness alongside scientific advance and technological breakthroughs are driving the NHS towards more health care being delivered in a non-hospital setting".

Insofar as Welsh health policy, too, correctly emphasises the need to switch the emphasis in health care from secondary to primary care, the increasing cost of medicines in primary care should be seen as a symptom of improvement, not failure.

Access to medicines and the primacy of the GP's clinical judgement

Finally, we wish to emphasise that at the centre of the primary health-care system is the relationship between the patient and their GP. While the pharmaceutical industry supports the development of supplementary prescribing and the closer involvement of pharmacists and nurses in developing patient care, we continue to oppose proposals which threaten the freedom of the GP, in consultation with the patient, to determine the most appropriate treatment for the individual. We believe the Assembly will need to examine carefully any proposal which, intentionally or otherwise, might reduce the range of treatments which are available to patients in Wales, for example by restricting the availability of a class of medicines to one individual product or brand. It would be unfortunate if patients in Wales were denied treatments routinely available across the border in England.

The Specific Recommendations of the Report

The Report's recommendations are contained in the Executive Summary (para. 6). In this section, we present some brief responses to each of these recommendations.

The NHS Directorate should determine and phase in any extensive changes . . ..to take advantage of any changes that the DoH may introduce as a result of its current review of generic procurement arrangements. But [it] should not accept undue delay while the DoH determines its preferred option.

We support the view that any changes to the systems for primary care procurement should be considered jointly with the Department of Health, and think the solution to "undue delay", if such were to arise, would be to press the Department to come to a conclusion, not pre-empt it in a potentially destabilising fashion.

The NHS Directorate should consider piloting centralised contracts covering a small number of medicines if the DoH does not make changes to procurement arrangements across the UK that would render centralisation inappropriate.

We have fundamental concerns about this proposal which we believe is based on a misunderstanding of the difference between secondary and primary care procurement. Whilst the industry has historically offered discounted prices under certain circumstances to secondary care, this has only been made possible because prescribing in secondary care represents a small proportion (around 15%) of the medicines prescribed and has recognised the fact of cash-limited budgets of hospitals. Indeed, as the Auditor-General recognises, quoting a report by OXERA "under the PPRS, revenues rather than prices are controlled. Thus companies are to a certain extent free to cross-subsidise between the hospital and primary care sectors" (para 3.21). In reality, the discounts offered by manufacturers across the whole of the market represent a realistic assessment of the minimum prices they can achieve while still generating a sufficient surplus for reinvestment in research and

development and payments to shareholders consistent with the PPRS. Attempting to realise discounts in primary-care purchasing risks displacing (or even eliminating) discounts to secondary-care and any assumption that similar levels of discounts offered in the past would be made available for bulk purchasing for use in primary care is mistaken.

We also believe that centralised purchasing risks destabilising the health care system which is based on individual contractors. It would risk destroying the freedom of prescribers in primary care reaching clinical judgements as to the most appropriate medicine to prescribe, and, like the OFT report, risk undermining the.commercial viability of community pharmacy, particularly in rural areas. Indeed, central purchasing of medicines on any scale is simply not compatible with the current framework of pharmacist re-imbursement In this context, we endorse the views of Community Pharmacy Wales and the BMA in Wales (paras. 4.7 - 4.11) and are encouraged by the views of Ann Lloyd, Director of NHS Wales, who, at the Audit Committee meeting stressed that "we have to evaluate risks very carefully. The last thing we want to do is destabilise the whole system, and risk people's supplies of appropriate drugs. We need to weigh those risks very carefully ...because we really need to make sure these services are available to all communities".

In planning any centralised contracts. . . the NHS Department should refer to the work done by the All Wales Drug Contracting Committee and the DoH to address security of supply and other practical arrangements.

In view of our opposition to centralised contracts for primary care, we have little to say on this recommendation. Given our view that the overall savings to the NHS in Wales are likely to be minimal by attempting centralised purchasing of primary care medicines, we would wish to flag up the risk of significant resources being wasted on purchasing services from consultants and advisors and on other costs such as ensuring adequate distribution networks to no meaningful end. Surely there is no suggestion that there is sufficient spare capacity elsewhere in the health care system to absorb this workload from within existing resources?

The NHS Directorate should take account of the effect of *procurement developments in undertaking its review of community pharmacy.*

We are broadly supportive of the Welsh Assembly Government's draft Pharmacy Strategy "Remedies for Success" and has provided a detailed response to that document. We believe that, as with the OFT report, the Auditor-General's report should be considered in the light of the extent to which it can help realise the goals of that Strategy rather than vice-versa. Any changes to the reimbursement system potentially threaten the viability of the community pharmacy network.

The NHS Directorate should set a national target for generic prescribing based on the current best levels achieved in Wales.

We support generic prescribing where appropriate, provided this reflects the clinical judgement of the GP and has no major problems with this proposal. We believe, however, that work on prescribing indicators within the All Wales Medicines Strategy Group runs the risk of being excessively focussed on costs not health outcomes.

The NHS Directorate should ensure that it recognises the potential links between initiatives designed to improve prescribing behaviour, such as prescribing and decision support systems, and developments in procurement arrangements and that it identifies the effectiveness of such initiatives taking account of those links.

We support initiatives which provide high quality advice and guidance to prescribers, and supports the development of local formularies, which can have a high degree of ownership by the prescribing community and can have educational benefits. Within WIG we have identified an annual investment of approximately L1m allocated to the continuous professional development of clinicians in Wales. However we have consistently opposed centralised initiatives, such as a Wales-wide formulary, which would undermine clinical judgement and restrict access to medicines.

The NHS Directorate should ensure that it recognises the potential links between measures to reduce medicines wastage thmugh better medicines management, such as pack side standardisation and developments in procurement arrangements and identifies the cost-effectiveness of those measures taking account of those links

We support efforts to reduce medicines wastage and endorse the approach outlined in "Remedies for Success", including the use of patient packs and reviewing the access to information by patients. We would point out that the evidence suggests that a significant contribution to medicines wastage arises from the substitution of medicines familiar to the patient with ones which may have the same clinical effect, but which differ in appearance or compliance requirements. We believe the Auditor-General has not taken this adequately into account in recommending the increased use of generic and therapeutic substitution. We were very encouraged by the support of Ann Lloyd, Director of NHS Wales, at the Audit Committee when she highlighted that the NHS in Wales was keen to work with the pharmaceutical companies on a whole range of issues such as patient information, original pack and pack size standardisation in order to improve patient compliance.

The NHS Directorate should assess how it could best support the development of supplementary prescribing while seeking to achieve the bents ofgeneric and therapeutic substitution.

While supporting appropriate generic *prescribing,* we have major concerns about generic *substitution,* where a pharmacist can overrule a prescribers decision on the use of a branded medicine without consulting either the patient or the doctor. In our view, this overrides a doctor's judgement regarding individual patients and thus undermines the doctor-patient relationship. It also risks an increase in non-compliance (patients failing to use the medicines which have been prescribed), particularly amongst the elderly who may be reticent to take a product which looks dissimilar to the one they are used to. We are fundamentally opposed to *therapeutic substitution* (the replacement of a prescribed compound with a different one) which challenges the accountability of the doctor for their patient's treatment.

At the same time, we support the development of supplementary prescribing and the .greater involvement of pharmacists with medicines reviews, provided these are undertaken in line with the patients clinical management plan.

The Process

As will be clear, ABPI Cymru Wales Industry Group has some fundamental concerns with the recommendations contained in the Auditor-General's Report. While we feel that the initial discussion before the Audit Committee enabled some of these issues to be aired, and appreciated the awareness of NHS Department officials of industry concerns, we were concerned at the fact that this report was considered as new business at a meeting immediately before the Assembly was dissolved for the elections. Should the Audit Committee in the new Assembly return to the subject, we believe it would be helpful if interested parties such as ourselves, Community Pharmacy Wales, and the BMA could be invited to give evidence.

Annex F

THE AUDIT COMMITTEE

The National Assembly's Audit Committee ensures that proper and thorough scrutiny is given to the Assembly's expenditure. In broad terms, its role is to examine the reports on the accounts of the Assembly and other public bodies prepared by the Auditor General for Wales; and to consider reports by the Auditor General for Wales on examinations into the economy, efficiency and effectiveness with which the Assembly has used its resources in discharging its functions. The responsibilities of the Audit Committee are set out in detail in Standing Order 12.

The membership of the Committee as appointed on 3 June 2003:

Janet Davies (Plaid Cymru) - Chair
Leighton Andrews (Labour)
Mick Bates (Liberal Democrat)
Alan Cairns (Conservative)
Jocelyn Davies (Plaid Cymru)
Christine Gwyther (Labour)
Denise Idris-Jones (Labour)
Mark Isherwood (Conservative)
Val Lloyd (Labour)
Carl Sargeant (Labour)

Further information about the Committee can be obtained from:

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