HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Homecare medicines services

Wednesday 21 June 2023

3 pm

Watch the meeting

Members present: Baroness Morris of Yardley (The Chair); Lord Bach; Lord Carter of Coles; Lord Laming; Lord Porter of Spalding; Lord Prentis of Leeds; Lord Shipley; Baroness Stedman-Scott; Lord Willis of Knaresborough.

Evidence Session No. 2 Heard in Public Questions 16 - 23

Witnesses

I: Richard Bateman, Pharmacist and Board Member of the Royal Pharmaceutical Society Hospital Expert Advisory Group; Alison Davis, Chair, National Clinical Homecare Association; Dr Rick Greville, Director, Distribution & Supply and ABPI Cymru Wales, Association of the British Pharmaceutical Industry.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of Witnesses

Richard Bateman, Alison Davis and Dr Rick Greville.

Q16 **The Chair:** Welcome to this session of the homecare medicines services inquiry of the Public Services Committee. I will start by asking today's witnesses to introduce themselves and thank them for giving us their time. I will then turn to Lord Carter to ask the first question.

Dr Rick Greville: I am the director at the ABPI, with responsibility for the supply chain and the distribution of medicines in the UK.

Richard Bateman: I am a pharmacist with over 30 years' experience in NHS hospitals. I am representing the Royal Pharmaceutical Society as a member of its Hospital Expert Advisory Group.

Alison Davis: Good afternoon. I am chair of the National Clinical Homecare Association.

Q17 **Lord Carter of Coles:** Again, thank you for your time this afternoon. This committee has received quite disturbing views from various users about the problems with homecare medicines services. Alison, perhaps you could help us to establish the cause of the problems that we have heard about.

Alison Davis: The reality is that homecare medicines services are multifaceted and multi-stakeholdered. There is no single root cause to the challenges, and you have probably all come to the same conclusion yourselves.

I can try to summarise some of them. Clinical homecare organisations provide services to over 500,000 patients, process in excess of 116,000 prescriptions per month, and make about 2.8 million deliveries per annum. It has not been without its challenges. We recognise that some providers have encountered issues to a lesser or greater extent over the time period.

As an example of what makes this difficult, in the arrangements that homecare providers and the NHS have with each other they work off paper-based systems. It is an administrative burden in all aspects of the registration and prescription process. Just to give you an idea of how that works, once the prescription is written it is signed by a prescriber and then sent to the hospital pharmacy team to clinically screen and create a purchase order number. The prescription, and the registration form where applicable, is then provided to the homecare provider either electronically or in the post.

Data from providers has demonstrated that it can take several weeks for those documents to be written by the clinical team in the clinic or on the ward before they make their way to the homecare provider, and an average of 14 days before they even come to the homecare company, which can cause delays in treatment and the initiation of treatment for new patients. That also means that the patient has an expectation: 'I've

been seen in clinic. I know I'll have my homecare service and I've not heard from that provider'. So what do they do? They pick up the phone. It is more burden on the clinical team, because they do not deal with the pharmacy team, which is what the homecare providers do. It puts extra effort and administrative burden back into the clinics and the prescribers.

Paper prescriptions that are sent in the post carry a high risk of delays or loss and are therefore potentially a data breach. It is very difficult to manage an audit trail of those paper documents as they have been sent. It is fair to say that the Royal Mail industrial action has caused some challenges. The impact has been not just in the days of industrial action but in the wealth of post that needs to be processed after those events. Again, that has caused further delays and backlog with those documents coming to homecare providers.

Although prescriptions can be sent by secure email and in the interest of urgency of patient care, there is no legal framework, other than the emergency supply regulations in the Human Medicines Regulations of 2012, which require a prescriber to communicate directly with a pharmacist and a wet-signed prescription to be received by the pharmacy without undue delay. This creates more administrative burden and double handling and duplication risks. Upon receipt of that prescription, regardless of the route of transfer, prescription receipt lists are created. They have to be signed by all stakeholders and go back to the referring hospital, again creating more administrative burden for all people who are involved.

We cannot shy away from COVID-19 and workforce resilience. At the start of the pandemic, there was an understandable drive to move more patients from secondary care and out of hospital care. Homecare providers worked very closely with the National Homecare Medicines Committee to transition patients safely from hospital to homecare. During that six-month period, 90,000 patients were transitioned out to homecare providers.

What did that mean for extra growth in the industry? The industry has been growing at about 10% in the number of active patients year on year for the last 15 years. In two years in particular, 2020 and 2021, patient size grew by 15% in 2020 and by 17% in 2021. Interestingly, that involved 700 new contract requests to the National Homecare Medicines Committee. Just to give you an idea, even 90,000 patients across trusts in hospital mean that a huge amount of contractual burden was also put on to the NHS.

Private providers face the same recruitment and retention challenges as the NHS, but the ability to redeploy staff has greater limitations. In a clinic or a hospital, for example, if you are short of staff, I appreciate that it is difficult but it is possible to redeploy staff, perhaps from another department, as you prioritise the workload. It is not the same for a homecare provider, which potentially has to send a nurse or a vehicle hundreds of miles from their location in order to treat patients, so it can be harder to cover sickness, absence and attrition rates.

On supply chain disruption, over the last few years we have seen a significant increase in the number of medicines that have been withdrawn from the market or are unavailable, or where there is limited stock available. This places a significant burden on the NHS and providers. Strategies to overcome situations like this may include the provision of new prescriptions—so more burden—for an alternative item, or rationing the amount of quantity that is supplied in that single fill. For a homecare provider, this means more telephone calls to patients or alternative modes of communication, and it can significantly increase the number of deliveries that are made to patients. Instead of a three-monthly supply, which is four deliveries a year, it could be a monthly supply, or 12 deliveries per year.

As organisations, we run off multiple IT systems. There is no single NHS system for providers to try to integrate with. Because of the non-standard approach, there is no systems interoperability. Homecare provider systems have been configured from a variety of standard order processing systems to meet the complex requirements placed upon them, whether from a regulatory or a commercial standpoint. All activity results in either paper or electronic communication for confirmation, such as patient visit forms or double hard key entry between stakeholders. Electronic invoices cannot be sent due to the requirement for hospitals to receive a separate proof of delivery prior to passing the invoice for payment.

Fundamentally, there is a lack of funding in the NHS for homecare teams. Despite the growth in homecare services, many hospitals remain without dedicated or sufficient staff to manage these services internally. Some pharmacy teams have managed, by submitting business cases, to build homecare teams in their pharmacy departments.

For most homecare services, NHS hospitals are to supply prescriptions a minimum of 10 working days before the patient is due a delivery. Unfortunately, again, due to the manual processes and their own internal capacity issues, this is seldom the case, and provision for late prescriptions to homecare providers puts additional burden on the operational issues. That said, the provision of a late prescription can also be due to patients not attending a clinic appointment or having a blood test, for example, so we cannot lay all that burden back on the NHS.

Unsurprisingly, patient expectations can sometimes cause some of the problems or challenges that we face. There is clearly a disconnect between the NHS clinical and pharmacy teams, which can result in patients being provided with unrealistic expectations of the services provided by homecare organisations. The standard specification for homecare lays out the expectations of the referring hospital and the homecare provider, but these are rarely seen by the clinical teams. For example, patients do not always understand why the medicines cannot be posted through their letterbox or left in their porch. Governance and pharmacy regulations prohibit this type of activity. So the problem is multifaceted.

Lord Carter of Coles: That is great, thank you. Clearly, there is a structural problem, and we will hear more about that, I am sure. In order to make the necessary adjustments as you go along, do you collect data about what is going wrong—for instance, in the whole pathway from the moment of a prescription? I was very surprised; did you say that it is taking 10 days to get a scrip written by the consultant out to the homecare provider?

Alison Davis: On average, it is about 14 days.

Lord Carter of Coles: I am curious, and perhaps, Mr Bateman, you can help us with that. How long does it take to get a scrip from the consultant to the internal pharmacy if that patient is an inpatient?

Richard Bateman: It will depend on the urgency, but it would usually happen on the same day.

Lord Carter of Coles: So we have a bit of a problem in getting the scrip out of the hospital and to the homecare provider.

Richard Bateman: To qualify that, that is for an item that is required there and then. If something is being prescribed because you know that you have a patient coming in in a week's time, that is a different matter and a different process.

Lord Carter of Coles: One would probably expect all things to be dealt with in a timely manner. As a national body, do you collect data about what is not working? If we asked you to separate those factors in the pathway, is it late scrips? Clearly, 10 days to get a scrip out for a patient who is waiting would seem to be quite challenging. What other things are there? I can understand the IT failure. There is none, it seems to me. Does it go into the EPR systems in the hospitals and out into primary care? Probably not. That is a structural issue, but what other operating issues are there? You referenced the shortage of staff. We are trying to get to the major factors; we are trying to get the hierarchy here. We can talk about the structure. Perhaps you have some views, Dr Greville.

Dr Rick Greville: Alison has captured a lot of the complexities very well, and her extensive list merits a lot of attention. Certainly the marketing authorisation holders as sponsors of a homecare service are of the view that they do not have intimate knowledge and understanding of the service as it is being delivered. They have good insight into the intended design of the service, but very often the feedback mechanism or the transparency in how successfully that service is being operated as a day-by-day function is sometimes missing. From the marketing authorisation holder perspective, they would prefer greater transparency in the data you mention.

Richard Bateman: That is a good overview. I would highlight that, as has been alluded to, there is a real issue with interoperability of IT systems. There is no single hospital pharmacy IT system. There are multiple systems. We deal with multiple homecare providers, all of which

have their systems. Linking all those together is the obvious way to go forward and improve things, but it will be a challenge to get that number of systems linked in and talking to each other.

The other point that has been raised and is very valid is about there needing to be a clearly defined national funding structure for the resources for hospital pharmacy homecare teams. As has been alluded to, there is a difference in existing funding in different regions' trusts, and there is no single funding model. The resources in different hospital pharmacy homecare teams vary greatly. By having one model, that can improve issues.

Another thing that we have to distinguish between is service failures and things caused by supply issues. Although I fully accept that, to a patient, the outcome is exactly the same, the fundamental cause of both of those is very different in the way we can manage it.

Q18 **Lord Willis of Knaresborough:** I am getting a little bit frustrated, even though this is only our second session. We are seeing what the problems are and everybody classes the problem somewhere else. You have now come with the classic, 'Well, give us more money and it will get better'. Quite frankly, it will not. You have a logistics problem here, in that the logistics between getting from patient to patient just do not exist. No matter how much you put into different organisations, unless you have a simplified, national way of operating logistics properly, you cannot do anything about it. My question to you and to Rick is: what are you doing about getting the logistics right?

I ordered some parts from Amazon this morning, and I know that they will be here tomorrow. I do not know and I do not care where they will get them from, but I know that what is on their site will arrive tomorrow morning. If they do not, I know that I can pick up the phone or go on to the internet and get straight to Amazon to get a response. It seems to be impossible to get hold of anybody responsible for this organisation at all, so everybody blames everybody else for parts of it failing, and at the end of the day the patients are the people who are left out and suffer. What are you doing about the logistics, and about getting clarity about who organises the whole thing? If you cannot do it, who should be doing it? Is that unfair?

Richard Bateman: No, that is fine. I understand, and it must look very frustrating from a patient point of view. I would hesitate to agree with you that we are just asking for money to solve the problem. There have been real issues for a long time, and they have been discussed for many years, in trying to find the correct resources to manage homecare in hospitals, but that is the hospital side of it and is not linked to what is going on in the homecare providers.

We should have a single approach nationally, and we should have equitable resources, whichever trust a patient is being treated by. What that also highlights—you have suggested that there is some fragmentation of who is doing what here—is that we need to have better

defined routes of accountability and escalation for dealing with these issues. If you look at some of the contracting routes for homecare, you will see that there could be improved escalation routes to deal with these issues on a national level, rather than multiple local conversations trying to deal with the same issues.

Lord Willis of Knaresborough: Just let me give you an example. I was doing some work with the Nursing and Midwifery Council on expanding the roles of both registered nurses and nursing associates when we were looking at reclassifying the roles. One was about giving nurses in particular more opportunity to prescribe as well as to deliver drugs to patients. A whole host of different organisations were wanting to do the same thing, and all of them were doing their own thing. We said to the Royal Pharmaceutical Society, 'Will you design the system for us?' You did, and everybody agreed to it. It just seems to me that you could be a lead player here.

Richard Bateman: The Royal Pharmaceutical Society has produced professional standards for homecare services, and those are available. They are used in trusts, and most trusts are working towards improving compliance with those.

Q19 **Baroness Stedman-Scott:** Thank you for coming today. Building on one of the points you made, Mr Bateman, we are very keen for you to briefly outline contractual arrangements for homecare medicines services. Which bodies commission services, where does the money come from, and how is that money routed?

Richard Bateman: For homecare contracts, we can look at three mechanisms. As you have heard, there are pharma-funded schemes whereby the homecare is included in an overall price that the pharma company making the product has given and negotiated with the NHS.

Secondly, there are a number of regional procurement hubs in the NHS that run framework agreements for the provision of homecare services, and trusts have the ability to choose from a number of those, and to select a supplier and enter into a call-off order with them, which forms the contract. For two very highly specialised clinical areas, there is a national contracting process in place. Essentially, there are three mechanisms for contracting for homecare services.

On the funding streams, the hospital initially enters into a contract with the homecare provider and pays them for the product and service as delivered. Then, in the hospital sector and in the NHS as a whole, there are a number of commissioning routes. There is what is now referred to as being in block, whereby a hospital receives a set sum of money for provision of core services and treatments. If something is said to be in block, the costs sit with the individual hospital. There will be other commissioning routes, either through the Integrated Care Boards now—previously they were through the Clinical Commissioning Groups—or through NHS England specialised commissioning for different therapies. In the case of those two, although the hospital pays the initial bill to the

homecare provider, the hospital then recharges the costs—what is referred to as the pass-through cost—to the ICB or NHS England.

Baroness Stedman-Scott: Could I ask all of you whether it would be better if there was just one contractual route, so that you did not get all these multiple transactions and different systems?

Dr Rick Greville: It is a really difficult question, so thanks for that. Would it be better? It is really difficult to know until we give it a go. That would be the honest answer. In terms of the schemes that are funded by pharma and by the marketing authorisation holder, there is a process and flow that I have captured on paper, and I am happy to take you through that, if that is at all helpful.

Initially, a marketing authorisation holder decides whether they should offer a homecare service as part of their offering to the NHS. Sometimes there is a perceived obligation or expectation by the NHS on marketing authorisation holders to bring these service offerings to the table. Nevertheless, the marketing authorisation holder has to decide whether it wants to bring these means of distribution in order to become available to the NHS.

It is important to remember, as we alluded to earlier, that homecare is just one of the routes whereby medicines can get to patients. There are other alternatives. Initially, there needs to be a decision as to whether a service can be offered. Once that decision has been made, the marketing authorisation holder has to design an appropriate service. It brings experience and engages with Alison's members, the homecare providers, that it has previously worked with to ensure a reasonable, good design. Increasingly, those designs are becoming more standardised as it becomes clearer what the NHS is expecting on an ongoing basis.

The next step is really important from the marketing authorisation holder perspective, which is that it ratifies that service or seeks the approval of the NHS for that service to be offered. That is a critical point as to whether the service is funded and whether Alison's members, as homecare providers, are commissioned to deliver that service. I will stop there. My flow goes on, but I am well aware of time.

The Chair: If you could let us have your diagram, that would be really good.

Dr Rick Greville: We will share that list with you. I wish it was a diagram, but it is a list.

The Chair: That would be brilliant. Thank you.

Baroness Stedman-Scott: No more exam questions from me.

Dr Rick Greville: No, it is fine. Not difficult ones anyway.

Lord Carter of Coles: Does every hospital have a different contract, or is there a national contract?

Richard Bateman: All the regional hubs will have separate contracts, but there is a standard service specification.

Q20 **Lord Laming:** I declare at the outset that I have no interests to declare in this matter. You know what I mean by 'interests'. I have a great deal of interest in the subject. I am very grateful for the open and honest way in which you have set out the difficulties and challenges in the system.

For someone like me, who starts from a position of very little knowledge or understanding of the challenges that you face, it comes across to me that the system is well-intentioned but is not working. It is very important that we create a system whereby important medicines can be got to very vulnerable people, and got to them quickly and efficiently. I just wondered, in the light of your experience, whether, if you three were required to produce a system that was a huge improvement on what you have at the present time, it could be done, or are we hoping and aiming for the impossible?

Alison Davis: Thank you for your question. I hear you and I do not disagree that, on occasion, the system is failing patients. Homecare providers collect 61 KPIs, which we provide monthly to the NHS, which go into regions and nationally, and to our pharmaceutical partners, where we are providing services funded by them.

In 2022, 98.8% of deliveries were delivered on the day they were intended to be delivered on. That means that 1.2% too many were not, and we need to do more about those. If I had a magic wand and could have my wish list of all the things that could make a difference, there is one fundamental challenge: specialty pharmacy services provided by homecare providers do not factor anywhere in government policy or strategy. The reality is that money often follows policy and strategy. There has been a lack of oversight and funding. Forgive me, I am not asking for more money, but I just do not think there has been any money. As a result, there is no named individual team or department accountable and responsible for those essential services to 550,000 patients. Some £4.1 billion of Treasury money is spent on these services per annum, yet nobody has oversight for it.

Homecare providers can be part of the solution. You are right that we are very well-intended. We all do the jobs that we do because we want to provide exceptional services to patients. Believe me, it hurts our staff as well when we do not deliver the services that we intend to. We are very supportive of this process, because we want the best possible services that we can.

One of the things is strategic oversight at a much more senior level, whether in the Department of Health or in NHS England, because nobody is accountable. Another is an electronic prescription service. We talked about paper. Somebody mentioned the primary care electronic prescription service. There is no such thing in secondary care. NHS Digital has been working on it for more years than I care to mention. We are not

there yet. That would take away a huge amount not only of burden but of risk.

It potentially also creates another opportunity. Somebody mentioned contract pricing and list pricing when it comes to homecare providers. Homecare providers carry a significant amount of working capital. A market to operate in is an attractive market. For example, where a NICE patient access scheme confidential price has been agreed with the hospital, homecare providers are paying list price for those medicines, and then they have to submit the invoice to the NHS at the agreed price and claim a rebate back from the homecare provider. This is all burden and cost, and the cost of working capital. If we had something like a secondary care EPS, could we claim back in the same way that a primary pharmacy does, whereby it simply submits a claim on a monthly basis into SBS and is repaid at source?

The Chair: You mentioned secondary service and then you gave some acronyms. Could you say those again?

Alison Davis: The NHS SBS—NHS Shared Business Services—is the agency that reimburses primary care pharmacy.

Systems interoperability is crucial. Again, we have been driving for that among patient systems as well. There are multiple electronic prescribing systems for homecare providers. As the NCHA, we have looked at whether we could create some sort of hub that would allow interoperability between the systems that the NHS uses for prescriptions. It is possible, but again we have to have the NHS on our side if we are to create something new and different for them.

My colleagues here also talked about contracts. It is also really important to know that 80% of clinical homecare services are funded by the pharmaceutical industry.

Lord Laming: In your reply to me, you said that there was something like 98% customer satisfaction, or whatever you were using 98% for, and that it was doing very well. I could not follow it, but that is me. Then you went on to set out a whole series of issues that are impeding the work, one of them being paper-driven exercises at the beginning, *et cetera*. What I do not understand—you must excuse my ignorance—is how all the things that you have set out, which seem to be obstacles and frustrations for you, can result in 98% satisfaction. It is that that I do not understand.

Alison Davis: That statistic was the number of deliveries made on the day they were intended to be made. It is not satisfaction of patients or clinicians. It is about on-time delivery performance, when medicines are delivered on the day they should have been delivered on.

Lord Laming: You then said that there are a whole lot of reasons why it cannot be done.

Alison Davis: Those are what will make it better. The reality is that, in order to achieve that 98.8%, a significant amount of work is done by my

colleagues in the NHS in the services they are providing and by the homecare providers. We throw people at the problem. Homecare providers have to employ a huge number of people to manage the manual processes. If we could put systems in place, we would not need so many people. We would not have so many challenges when those people are perhaps not available.

Q21 **Lord Prentis of Leeds:** My question is about standards and accountability. You have explained a lot of the difficulties that you are experiencing as you are dealing with this area of the health service. What quality and safety standards do homecare medicines services have to meet? Tell us about the criteria.

Alison Davis: We report to KPIs, which are part of the standard specification of homecare. They form part of the RPS standards in the homecare handbook. We have had other versions of them since they were first launched. There are 61 KPIs, which cover things like on-time and in-full deliveries, the number of complaints from patients where we have part-delivered, and safeguarding issues. The handbook is available in the public domain, but I am happy to send it over if that would be helpful.

Those are just the KPIs. Each organisation is strongly regulated. For all medicines activity, they are regulated by the General Pharmaceutical Council. Any organisation that provides nursing services will be regulated by the care regulators, which is the CQC in England, the Care Inspectorate in Scotland, and the equivalent in Northern Ireland. There are some providers that either make compound and licensed medicines or do wholesaling activity, and they would be regulated by the MHRA.

Lord Prentis of Leeds: Who is responsible for ensuring that the KPIs or other standards that are put in place through regulation are met?

Alison Davis: For a homecare provider, the reality is that it is a different regulator for their section. Homecare providers are inspected based on their inspection schedule and the degree of risk that is deemed by the regulator. In an organisation, if it is a pharmacy activity, it will be their superintendent pharmacist who is accountable. In nursing services, it will be whoever is their registered manager or their nominated individual. In the NHS, on the back of the Mark Hackett review that was completed in 2012, it is pharmacy. Accountability at the hospital level sits with the chief pharmacist, who can devolve responsibility for day-to-day activities, but, ultimately, they are accountable.

The Chair: We will come to that in one of our other panels.

Lord Prentis of Leeds: Just following that through, though, you mentioned accountability and standards regulation. You have been really helpful to us in pointing out where the difficulties arise and where the barriers are in place that lead to the system being as it is now. If regulation is to work, you must have been saying this in the regulatory system and in the health service to all the organisations that are

involved. Has nobody picks up the difficulties and sought to overcome them?

Alison Davis: I cannot speak for individual organisations. I am representing the industry. Where organisations have had a large number of issues, my knowledge is that the regulators have addressed them with them individually as organisations, and they have been under quite significant scrutiny over time.

The Chair: Has anyone had the sort of conversation with you when you say, 'Things clearly are not going well. Just read the press or read the letters, or look at the correspondence'? It is about the sorts of things that you have all asked for: 'If we had A, B and C, it would be better'. It is not outside of the inspection, because we will talk about that. Has no one had this sort of conversation with you and said the equivalent of, 'Let's get together and see if we can build a different structure'?

Alison Davis: We have been reaching into the NHS to the extent that we can.

The Chair: You do not feel that they are talking back to you.

Alison Davis: No, and the challenge is that the National Medicines Homecare Committee is a subgroup of PMSG, which is a subgroup of a subgroup. It comes back to who is accountable and who is taking ownership of this in the NHS. Please do not think that I am pointing a finger at the NHS.

Lord Prentis of Leeds: No.

Alison Davis: We want to work with them, and there are some incredible people who work at local, regional level and national level in the NHS, but they have no power.

Lord Prentis of Leeds: I have a final, very short question. You have been very honest with us in setting out the length of time that it takes for the process and then delivery. One area that really concerns me is that, when the prescription is written, it stays in the hospital for 10 days. Why? Is it just in an in-tray?

The Chair: Let us go over to Mr Bateman or Dr Greville for that. That does seem to be a bit from mystery to those of us who are not involved in this.

Richard Bateman: A lot of the pharmacy homecare teams in hospitals are underresourced, and we can argue whether that is due to a lack of funding or other reasons. You will see that people get pulled into other operational issues. There are massive staffing challenges across the whole pharmacy workforce at the moment, and there is a lot of work going on nationally to look at and address this.

That is the background that we are looking at, but we do not have an agreed funding and resource mechanism that is equitable across all

providers. We also have a huge workforce challenge. Although people will have a key role in homecare services, they will inevitably get pulled into a lot of other day-to-day operational things going on in the hospital.

Another point that is really important to make, which has been brought up here and previously, is about the routes of escalation and accountability to senior levels. It has been mentioned that there is a struggle to link into the right level in the NHS. Not to make any specific examples of providers, but there are issues in trusts or at a regional level, and there is a dialogue with companies. There is not a struggle with all of them, but there can also be the challenge that you are not linking in with people at a level who can make systemic changes. That has to go away and work its way through a separate process in the provider. That is not always the case, but it can sometimes happen too. It is really about better accountability right the way through, from the homecare providers, through the trusts and to senior levels in the NHS.

Q22 **Lord Shipley:** Can I pursue that better accountability? Alison Davis, could you clarify some of the words you have used in replies. Earlier on, you used the words, 'No one has oversight', and I would like you to explain a bit more what 'no one' and 'oversight' mean.

Secondly, you said a moment ago that, 'We're reaching into the NHS', but the people you reach into do not have power. I would like to know who does have the power to do something about this.

Thirdly, can I just clarify your 98.8% of deliveries taking place on the day they are supposed to arrive? I want to be really clear about this, because there is so much evidence of prescriptions being written and then taking days to be processed, so I am having difficulty understanding how that KPI, of which you said there were 61 in total, works. Is that 98.8% figure a real one or is it based upon huge delay, whereby you got it on the day, even though the day that it was supposed to be delivered was a long time from the point at which the process started? If there are 61 KPIs, we have had difficulty finding them. We do not know exactly what you are collecting or publishing on provider performance, or to whom provider performance is being made available and on what basis.

The Chair: There are a lot of questions there. Let us start with those 61 KPIs, because that is a really good question. Where are they? When you said they were published, is your performance against those published?

Alison Davis: The performance is not published. The datasets that are collected are available on the RPS website. All homecare providers report on a monthly basis their KPIs at service level and hospital level to the hospitals that they are contracted with. They need to be with them by the tenth working day of every month. They also report them at regional level. Where you have a regional procurement hub that is acting contractually on behalf of multiple hospitals, they get the collective data for all the hospitals. The National Homecare Medicines Committee also holds national stakeholder engagement meetings, so the providers report at national level as well. The data is being supplied to the NHS on a monthly basis and is being reviewed with providers to the best of their

ability, where they have availability, in order to be able to meet with the providers to go through their performance.

Lord Bach: Why is it not being published? What is the reason for that?

Alison Davis: I am not trying to dodge the question, but it is a question for the NHS. It is the NHS's data. It goes into the NHS.

The Chair: We shall ask it in the next session. Do you collect the numbers of complaints?

Alison Davis: Complaints are in there too. I will happily forward the spreadsheet.

The Chair: That is one of the 61.

Alison Davis: Yes. As an industry body, we collect the data and it gets aggregated anonymously. Although we do not publish it, it is in the public domain at a limited level, because we present it at our members' meetings and at our annual conference. Those highlight industry stats such as complaints and incidents, on-time and in-full delivery performance, and how much the Treasury is spending. We do present those, but we do not publish them.

Lord Shipley: You use phrases like, 'We report into the NHS', but I do not know what that means. Who do they go to in the NHS? Maybe we will pursue that in the next session, but it is like it is going into a huge bureaucracy and nobody quite knows what that is and who is then responsible for the publication.

Alison Davis: In an individual NHS hospital, they will be sent to whoever we, as a provider, have been asked to send it to. It is usually a homecare pharmacist. Sometimes they go to the chief pharmacist, but each hospital will nominate who is responsible to receive that report in that organisation. At a regional level, it goes to the regional lead. Each region across the NHS has a regional lead for homecare, and the regional data goes in to that named individual.

Lord Carter of Coles: Should it end with the chief pharmacist and the National Health Service in England? If you wanted to really change things, is that who you would like to talk to?

Richard Bateman: A degree of responsibility will sit in the pharmacy. In the breadth of the services delivered by homecare companies, it is more than simply the supply of medicines. It brings in aspects of nursing care as well, so it is not purely a pharmacy service. This is just speculation on my part, but perhaps that is part of the reason why it has proved difficult to really see that ownership of it. It is not a service that necessarily sits comfortably in a single professional group.

Lord Carter of Coles: Nor does most healthcare, I am afraid. It is complicated. Every piece of healthcare interrelates with other things, but you can usually track the accountability.

The Chair: It might be unfair of me to say this to Dr Greville and Mr Bateman, but in the wide range of things that you do as part of your job, it is almost as though this gets the least attention. It is not at the top of anyone's priority list, so it keeps getting slightly ignored. It is always there, but not of high enough order for somebody to say, 'Let's sort this problem out'. Is that an unfair perception, or is there an element of truth in that?

Richard Bateman: It is probably not fair to say that it is not a high priority for people, because hospital pharmacy homecare teams are working very hard to do the best they can with the resources available to them, and that is across the system.

The Chair: But who is committed, then, to developing them in the hospital?

Richard Bateman: It goes back to the point that has been raised a number of times about the route of escalation and where the senior level ownership sits. It is not for me to define where that would be.

Dr Rick Greville: From a marketing authorisation perspective, it is much easier, because they are generally much smaller organisations than the NHS. The structure, the reporting lines and the strategic oversight are certainly there. As I mentioned earlier, when marketing authorisation holders initially designed the homecare service, that required senior leadership sign-off in our members before it saw the light of the day.

Q23 **Lord Willis of Knaresborough:** Lord Shipley did a good job and, Alison, you did an even better job in answering that core question. The Committee took on this inquiry and we have become absorbed by it, because clearly if we make the right recommendations, with the support of bodies like yours, we have a chance to do something, which is why we are very excited about the whole work. If we get annoyed at times, it is because we love you rather than anything else.

You brought up a number of things, Alison, that we should recommend. The first was oversight. We do not have a clear answer from any of you as to where that should be. Who should it be? Which Minister should you report to? Who should report to them? Who do you cascade to thereafter? That is a simple question, so could you give us a clear answer?

The second thing was this business of how you align with pharmacy services. I found it quite staggering that there is such a strong divide between homecare and pharmacy services. How can that be solved? It seems to me that that should be a relatively easy thing to solve, so how would you propose to do that?

On the interoperability between current pharmacy services, which quite frankly are excellent in the way in which particularly GPs and patients now very efficiently get their drugs, if we can match that with your services, we are suddenly into a different ballgame. How can we do that? Who should sort electronic prescribing out? Should it be the NHS? It then goes back to who will be responsible in the NHS to drive it. We need an

answer to that.

I am really unclear about the pricing system. If you talk to the Royal Pharmaceutical Society, one of its biggest concerns is that the current pricing system between the NHS and pharmacists is hopeless. It does not work, because if you prescribe too much of a particular medicine, you suddenly have to pay it back and get it somewhere else. The whole thing does not work. Who could sort that out? Should that be the Royal Pharmaceutical Society? I would really like some answers to that.

Finally, Rick, how do we sort the logistics out? Does that simply go to the private sector so that we see high-quality experts delivering, perhaps through artificial intelligence and very good algorithms, the sort of quality that will mean that it is not 98.5% but 99.99% customer satisfaction and that it comes without the cost, which you brilliantly described, Alison, of what goes on to achieve the present thing? That is the final question.

The Chair: Let us start with the logistics, because that is where we started this discussion, so we will just break that down. Lord Willis has suggested it would be easier if it got contracted out and was given to a specialist logistics supplier.

Lord Willis of Knaresborough: Do you agree with me?

Dr Rick Greville: The system currently is already privatised to a large extent. Alison's members are funded either by the marketing authorisation holders 70% to 80% of the time, or by the NHS for the remainder of the time.

Lord Willis of Knaresborough: So there is no problem with the logistics, then.

Dr Rick Greville: I am not saying that there is no problem with the logistics. I am saying that the answer of prioritisation is the answer that we currently have. It is a privatised system. Alison's members are not part of the NHS. They are contracted indirectly or directly on behalf of the NHS, so that private provision is already in place to a large extent. That is what I was getting at.

Privatisation probably is not the answer, or will not necessarily give a better answer than currently, although I have to admit that 98.8% is a phenomenally good figure. It is not perfect, but the discussions that are being had are to create perfection, because every patient demands, expects and deserves to have the medicine they need at the appropriate time. We are looking for perfection here. We do not have perfection. Are there means of reaching or approaching perfection? Yes, there are.

Lord Willis of Knaresborough: Sending drugs 500 miles to people in order to meet this target cannot be right.

Dr Rick Greville: I am just reflecting on Alison's comments about the 98.8% success.

The Chair: It is 98.8% delivered on the day they were meant to be

delivered on, but that does not necessarily mean the day the patient thought was appropriate.

Lord Carter of Coles: Does that factor in 10 days writing a prescription?

Dr Rick Greville: No.

Lord Carter of Coles: I cannot reconcile Lord Shipley's point. Could we return to that? On the face of it, 98 point whatever per cent is as good as most KPIs I have ever seen. Most people would be absolutely delighted with 98%. Why are we picking up incredible disquiet from users on the one hand, and getting what looks like a crackerjack KPI over here? What is the basis of the calculation? Does it factor in that it is slow and that these things say they will come that day, but, in fact, might not meet the patient's needs? Could you help us with that? That is central to it.

Alison Davis: On delivery, homecare providers do factor in the time it takes. There are standardised processes among providers. Another obligation of a provider is a prescription reminder service. A bit like when somebody at home asks for their FP10 from their GP, homecare providers request prescriptions from specialist centres or from pharmacy teams, and they take into account how long it takes to get a prescription.

We have not mentioned the patient in any of this, but the provider then has to call the patient. Again, we have standard processes for the number of times we try to contact patients in order to schedule their deliveries. If a patient is due a delivery on 1 June, for example, that process starts several weeks before that delivery date in order to try to achieve that 98.8%. The reality is that that statistic is based on the day that was agreed with the patient. You are absolutely right: it does not mean that that was the day the patient was due it.

Lord Bach: Did you mention the figure of £4.1 billion?

Alison Davis: Yes.

Lord Bach: I think you mentioned the Treasury as well. Maybe I have got this wrong, but the figure that we received earlier seemed to me more like £2.1 billion. It may not be you who can answer this question. Why do you say £4.1 billion? What does that represent?

Alison Davis: That is a really good question. It is effectively the value of invoicing by homecare providers. I said that the NCHA collects aggregated data on spend from all providers, so that is the number as of December 2022 and it does not take into account where we are this year on growth. The number you were quoted at last week's session was the number we published some time ago. It is really important to know that the vast majority of that money—at least 90%—is the cost of the drug.

Lord Bach: I am not arguing that. So the figure has being moved forward and is now accurate until December last year.

Alison Davis: Yes.

The Chair: Thank you for your time. You can take it that we are still trying to understand what is beneath a lot of the figures and complaints that we have seen, and you have helped us to take a step forward. If, on reflection, when you perhaps have time to look at the transcript, there is anything that you feel you could add to the myriad questions that members have raised, please do feel free to write to us. It will still be evidence and we would be able then to take it into consideration. Again, we are really interested in the data. As well as the 61 key performance indicators, if you collect any other performance data in any of your parts of this business that you could let us see, that would be really helpful. Until we hear from you again, thank you for your time and for the patience with which you have answered our questions.