



Public Services Committee

Corrected oral evidence: Homecare medicines services

Wednesday 13 September 2023

3.20 pm

Watch the meeting

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

Evidence Session No. 5

Heard in Public

Questions 49 - 59

Witnesses

[I](#): Will Quince MP, Minister for Health and Secondary Care, Department of Health and Social Care; David Webb, Chief Pharmaceutical Officer for England, NHS England; Rahul Singal, Chief Pharmacy & Medicines Information Officer, NHS England.

Examination of witnesses

Will Quince MP, David Webb and Rahul Singal.

Q49 The Chair: Good afternoon and welcome to this session of the inquiry into homecare medicines. Today, we are delighted to welcome the Minister, Will Quince. Minister, would you like to introduce your colleagues?

Will Quince MP: I certainly would. Thank you very much and apologies for the delay in getting here, with the votes. It is probably best that they introduce themselves.

David Webb: Thank you. I am Chief Pharmaceutical Officer for England.

Rahul Singal: I am the Chief Pharmacy Information Officer.

Q50 The Chair: Thank you for your time. As I think you already know, the meeting is being recorded and you will get the opportunity to look at the transcript before it is published. On the whole, we intend to put our questions to the Minister, but, Minister, please feel free to draw in your officials as you see fit.

Briefly, Minister, what is your vision for homecare medicines as part of the NHS? What are your hopes and ambitions for the service?

Will Quince MP: Thank you very much. I very much welcome this inquiry. From a ministerial perspective, I certainly was not alive to some of the issues that the inquiry has drawn out. Although it is fair to say that conflicting evidence has been brought before the Committee, as a Minister my overriding concern is always patient safety and patient outcomes. Given the evidence that patients have experienced poor service and poor outcomes as a result of the service, it is something we need to look at very carefully. Although it is wholly managed by our arm's-length body, through NHS England, then through individual trusts and chief pharmacists, and then obviously the homecare providers, inevitably we take a close interest in areas where things are not going as well as we would want them to.

It is clear to me that it is an area that is expanding. We already have about half a million patients receiving the service. It is only likely to grow. From statistics I was reading recently, the population in England is forecast to grow over the next 15 years by about 4%, and the over-85s by 50%. We know that we are living longer with comorbidities and major complex conditions, which means that services like this will increase significantly, so we have to get it right.

I welcome the inquiry and the evidence that has been given. I also welcome the action that NHS England is taking, first, to look at this through a paper-based exercise and, then, to take on board the actions that are necessary to make the amendments required.

The Chair: I am sure we will want to come back to quite a few of the things that you have just raised in further questions. We will all be

pleased that you have acknowledged that all is not well. To put it bluntly, it has come as a surprise to us how such an important service has gone under the radar at every level; it does not seem to be satisfactory. Your first comment was very right in that you cannot get the same story from different parts of the system. That makes me think that, if there is no story to be told, there is no accurate information to tell the story. We do not want to go through every bit, but, for example, how much money is spent on homecare medicines per year?

Will Quince MP: We do not have an exact figure. I will need to defer to NHS England, specifically. I do not know whether my colleagues would know that figure. We certainly do not have verified figures, but it will be in the low billions if it is about half a million patients, so I would have thought that the vast majority of the figure would be the cost of medicines themselves. I would be very happy to write to the Committee once NHS England can give me a more accurate figure on that.

The Chair: That is exactly the point. We put down some Parliamentary Questions that go to the core of the problems we want to address with you today. We put down a Written Question, and the answer, obviously from your department, was that the cost is an estimated £3.2 billion. That is fine, but, 20 days earlier, the National Clinical Homecare Association had said that it was in excess of £4 billion. That is a problem; with two quotes, within 21 days of each other, there is a 25% difference. One says £3.2 billion; one says £4 billion. If we do not even know how much money is being spent, I just do not know where the department is. I cannot think of any other area, any other bit of your brief, where none of your officials could accurately say, 'Minister, this is the budget'. That has to be a problem. I could have picked a whole host of examples of where the department does not know what is happening.

Will Quince MP: I broadly agree with the assessment that we need better granularity of detail on finances, but it is important that we give the context, which is that the department is not directly responsible. We are accountable to Parliament, but it is NHS England, and then through individual trusts. What we have to ensure, and where I totally agree with you, is that we have clear accountability at local level to NHS England, so that we understand the figures there. Having just looked at my notes, the figure you quoted is the one I also have in my pack. I would be very happy to follow this up and get a more accurate figure and write to you.

The Chair: Minister, I would have thought that, because you do not have direct control, the importance of accurate data is even greater. It is the only way you know where public money is being spent. At the end of the day, the public will think you are responsible for it.

Will Quince MP: Ultimately, on so many areas across the NHS, sometimes to my frustration, I have all the responsibility and not all the levers—as you know yourself, Chair.

The Chair: I understand that.

Will Quince MP: To some extent, we have arm's-length bodies for a reason. They are given 'the' budget and it is their responsibility to manage that accordingly. It will be different in every individual trust. Where issues are highlighted, it is right that NHS England and, when concerns are escalated, the department would want to delve into that. I share your concern in that I would, of course, like to have more visibility of the funding at individual trust level but, certainly at NHS England level, for how much is being spent in this area.

The Chair: You said you had some figures in your pack. Are the figures in your pack £3.2 billion or £4 billion?

Will Quince MP: I think £3.2 billion was following the written question. Yes, that is the figure that I have, too.

Q51 **Lord Shipley:** Do you mind if I pursue that line of questioning? Minister, you have just said that the department is not responsible for the service but that it lies with NHS England and individual trusts. I am, therefore, not clear how you know that it costs £3.2 billion. I am not clear about who brings it together. Where does the buck stop? Who is responsible when there is a problem that is reported by an individual trust—you have kind of indicated that it lies with NHS England—and that might escalate up to the department? You began by saying that the department is not responsible. I would like you to be as clear as you can be as to who is responsible for running this service and being accountable for it.

Will Quince MP: I/we—as in, the department—are wholly accountable to Parliament. Ultimately, we are responsible in every way. However, the delivery of the service is wholly the responsibility of NHS England, devolved to individual trusts.

The experts sitting on either side of me can correct me if I am wrong on this. My understanding is that there are the homecare providers, for which there are 61, I believe, KPIs.¹ They sit under the control of the chief pharmacist of an individual trust or foundation trust. They are accountable and responsible not just to patients but to the individual trust boards. In between that, there is the National Homecare Medicines Committee, which is a side body. Ultimately, the trusts report to NHS England, which we fund, to provide the services. There are also further arm's-length bodies: the MHRA, the CQC for inspections, and the General Pharmaceutical Council, which is not an arm's-length body but a separate organisation and nevertheless has an interest. Sitting above NHS England, there is the Department for Health and Social Care, the ultimate commissioners, in that we provide the funding and are accountable to Parliament. I have tried my best there, but it is complex.

¹ The Department would like to make a correction to the figure of 61 for the KPIs. As part of the desktop exercise NHS England are undertaking they have clarified that there in fact 27 KPIs contained in the spreadsheet at Appendix 10 to Royal Pharmaceutical Society's 2014 handbook. There are 61 rows in the relevant tab in the spreadsheet (called 'KPI definition'), but 34 of these are data definition entries from which the 27 KPIs are then calculated using set formulas. The Department apologises for this misunderstanding.

Q52 Lord Willis of Knaresborough: Minister, you have clearly described the chaos that exists.

The Chair: Yes.

Lord Willis of Knaresborough: You have described to us quite effectively—thank you for that—the fact there that are so many different players within this service, none of which is fully accountable for anything at all. I do not see how you can carry on saying that this is a system that will be expanded significantly. It has gone up by 150% in a relatively short period, yet throughout the country you have an array of different organisations, none of which is singularly accountable to anybody other than its local piece. Surely, it is time to do something different about it.

Will Quince MP: Although I hear you, I do not entirely accept the premise. As complex as what I just described is, and it may be particularly complex—

Lord Willis of Knaresborough: Can I give you one example?

Will Quince MP: Of course.

Lord Willis of Knaresborough: You are sitting next to the chief pharmacist. You now have a set of pharmacists in local areas who are responsible, but they are not responsible to the chief pharmacist. The chief pharmacist is not responsible to the NHS, and the NHS is responsible to you. But that whole system does not work. The chief pharmacist, when we met him before, could not tell us anything about a number of those issues, because, 'I'm not responsible for it'.

Will Quince MP: I hear what you say. The situation that you describe—although I would say that it is probably a little more complex—

Lord Willis of Knaresborough: It is not your fault, by the way.

Will Quince MP: No. That is okay. Ultimately, a lot ends up at my door, but that is fine. The situation I have just described is not very different from most services provided across our NHS. We talk about a national health service. The truth is that, across the country, we have trusts that are autonomous organisations, sitting under NHS England, which have budgetary control, responsibility and accountability to their own individual trust. In a large respect, that is a good thing, because it means that they serve their local population; they best know the needs of their local area. They can be agile and adapt accordingly. It does, however, provide some frustration when we do not have good visibility at national level, through NHS England or through the department, of exactly what is going on in a trust.

I would take issue with any question over accountability, because there is accountability throughout the process. What I described—the individual homecare providers that fall under the chief pharmacist sitting under a chief exec, a board and a chair, a non-exec team, of an individual foundation trust, for example—is that if there is an issue, they are

accountable not just to that board and to NHS England through the National Homecare Medicines Committee, but to the Care Quality Commission through inspections, and then ultimately to NHS England.

Lord Willis of Knaresborough: If you look at transport, you have, in virtually every city of the United Kingdom and every county, different transport systems, all of which apply themselves to a set of criteria set down for them all to operate in. That is not the case here. You have totally different set-ups in particular regions or within particular NHS trusts. Surely, the idea of creating some uniformity in the overall plan that you are working to will make sure that everybody applies the same set of standards.

Will Quince MP: I totally agree with you that having a set group of strategic objectives and KPIs is really important. Where I would disagree with you is this: uniformity is not always our friend. We know, through health inequality and issues around the country, not just in health but in other areas of government, that having the agility at local level to be able to adapt the service to your local need and population is really important. Something that might work in Bradford could be very different from Colchester, the city I represent. That is why we have Integrated Care Boards, individual trusts and foundation trusts that take those decisions at local level, to adapt the service to their local population need.

I totally agree with you that there has to be a framework where we can objectively judge the services. That is where having a set of standard KPIs and a transparency of return at local and national level would be a welcome step. The committee has already highlighted that through the inquiry.

The Chair: We will come on to the KPIs. To be clear, I see the point entirely about local delivery of services. We are all in favour of it, but it needs more data. What we have at the moment with this service, starting with the patient, is the patient's hospital contracts with the medicine provider and the medicine provider contracts with the homecare service deliverer. The NHS has no contact with the homecare service deliverer; it is not party to that contract. It is not published because of commercial confidentiality. That is where the patient is. Where else in your brief, which other bit of the NHS, with a devolved NHS trust, is so distant and has no visibility of the contract through which their money is being spent and their patients are being cared for? I cannot think of anywhere else like that.

Will Quince MP: I will have to give that a little more thought. There are certainly numerous areas where ICBs and individual foundation trusts have full autonomy over purchasing. In some areas, it will be through a national framework; in others, they will have lots of local discretion. I will take that away and give it some thought. I will be very happy to write to the committee once I have given a bit more thought to where else that might exist within ICBs and trusts.

The Chair: We have moved on to accountability. We were going to have

a separate session on this, so we will start it now.

- Q53 Lord Laming:** Minister, it is good to see you. Thank you very much for already trying to explain how the system actually works. We have received a great deal of evidence from various organisations. The chief pharmacist was one person who came and helped us. What that evidence has found, certainly as far as I am concerned, if I may be personal about it, is that it is extremely difficult to identify any system of accountability in the service at all. The fact that there are local variations is perfectly reasonable. We would expect that; it is a service to meet local need and individual need. That is fine. There is no dispute about there being local variations. What concerns us is whether those are just free spirits or whether they are part of a system where there is some accountability for finance, for standards of provision, *et cetera*.

Perhaps I could quote for you from a letter—a ministerial response I received the other day after I had asked His Majesty's Government what assessment they had made of the performance of the National Homecare Medicines Committee, which you just referred to. The answer is: 'The Department has not made an assessment of the performance of the National Homecare Medicines Committee. Providers of Homecare Medicine Services to National Health Service patients do so under framework agreements and contracts which may be held at national level through NHS England, regional level through NHS procurement hubs, or local level through hospital trusts. This therefore requires a high degree of centralised co-ordination for which the NHMC liaises with homecare providers through their trade association the National Clinical Homecare Association to support and co-ordinate development of the homecare market and discuss any systemwide issues. The NHMC includes representatives from the NHS, including NHS England and Pharmaceutical officers, homecare providers, pharmaceutical manufacturing associations and the Care Quality Commission'.

The picture being painted for us is that this is an un-coordinated, unaccountable system, which is getting bigger and bigger as the years go by, costing more and more money, but there seems to be no way of sorting it. I will come to KPIs in a moment, if I may, but perhaps I may just stop with that question.

Will Quince MP: It is certainly complicated. That is an understatement. The accountability ultimately lies at the local trust, through the chief pharmacist and then the board. That is also, incidentally, where any patient who had a complaint about service, through PALS, would tend to go in any event. David, would you like to add any more?

David Webb: No. That is the locus of control in the way the contracts for home care operate. The committee will remember the way things are arranged; about 80% of all homecare is commissioned by the pharmaceutical industry.

Will Quince MP: Manufacturers themselves.

David Webb: There are SLAs in place with local hospitals to deliver on those. There are about 26% where the contracts are regionally created, but they are called down by individual trusts, when they choose to enact them. About 4% of contracts sit with NHS England for some very specific high-tech medicines. The locus is always within the trust that holds the contract with the homecare provider.

Lord Laming: We have had two contrasting kinds of evidence. There is the 89% that you quote, Minister, which is the one that trips off the tongue very easily. But there are the local people who have given evidence that sometimes there are gaps in the service provisions, sometimes there are delays, and sometimes prescriptions that are handwritten are misunderstood. There is a whole series. I will not go through them all. We now have, we are told, 61 KPIs, but we do not understand how those KPIs are actually used. Who uses them and what do they tell us?

Will Quince MP: David might want to answer that. The KPIs will be for the chief pharmacist to hold those providers to account, and he is, in turn, held to account by his own trust board.

The Chair: We are not sure locally that they have to use those KPIs in the contract. They can choose whatever KPIs they want. They do not have to use the 61, do they? That was our understanding.

Lord Willis of Knaresborough: They were never published or printed.

The Chair: No, they were never published. Ah, they are published, I think, but not the performance against them.

David Webb: Last time I was here, we undertook to publish the national collation of KPIs. That was one of the actions we took away. They are used in contract management discussions, which are between local hospitals and the homecare providers. They are also shared regionally and nationally in the National Homecare Medicines Committee. The reason for that is that, if there is an issue for a local provider with a single homecare company, those issues may be encountered in other parts of the country with the same homecare provider. The reason for taking them up to the NHMC is to see that broader geographical impact.

There is also an escalation route for the NHMC if service provision is not of an appropriate standard, which is to require the homecare companies to inform every chief pharmacist in a trust, to whom they provide a service, of what the issues are, what the mitigations are and what plans they have for recovery of that service. There is some feedback from the NHMC to local trusts.

Lord Laming: This all seems rather confusing to us, and that is putting it nicely and gently. If an organisation has 61 KPIs, that tells you something about the organisation—purpose, service delivery and accountability. Those are the critical issues for KPIs. In this kind of operation, 61 seems to most of us to be extraordinary. Do you agree?

Will Quince MP: I am not an expert in NHS contracting, so I do not know how having 61 KPIs compares with other contracts that are awarded through ICBs or trusts. I can look into that in more detail. It does seem like a lot, but a broad range of services is being provided. Ultimately, there are patients. There will be some KPIs that are standards-based, some are safety-based, and some will be locally specific, I suspect. I cannot really give you a view. It seems like a lot, as I say, but because I do not know the context of other contracts, it is very hard for me to give you a clear answer. David, you might have more experience.

David Webb: You might recall Joe Bassett from the National Homecare Medicines Committee, who attended with me, and Claire Foreman. The National Homecare Medicines Committee is going out next week to consult on the next raft of KPIs. They are, to my understanding, being expressed from a patient point of view as opposed to a transactional point of view. That is because some of them may relate to their hospital as well as to the homecare provider, to get the totality of the picture. It is on those new KPIs that we will attempt to publish the national collation, as we agreed to do.

Lord Laming: One final question from me. I hope this is not an unfair question, Minister, but does it seem odd that, despite 61 KPIs, we cannot describe a line of accountability in this service?

Will Quince MP: I might need to press you a bit more. By line of accountability, what do you mean? There is a clear line of accountability through the chief pharmacist and the individual trust. Do you mean all the way up to the department?

Lord Laming: I meant for somebody who is not getting the service, getting the wrong service, or having complaints. They do not know who to turn to.

Will Quince MP: I see. It is from a patient's perspective.

Lord Laming: Yes.

Will Quince MP: I see. Apologies. That is an area that concerns me, having looked into the evidence provided to the inquiry. It is really important that patients have a clear escalation process for complaints because that is how we put things right. If that is not working, through the desk-top, paper-based exercise that NHS England is undertaking we need to look at what more we need to do to ensure that patients have a clear pathway to escalate a complaint so that it can be addressed as quickly as possible. Some of the complaints I read about, causing not just emotional but financial distress to patients, are very concerning.

The Chair: Harm.

Q54 **Baroness Bertin:** To build on that point a little and to press you on the NHS trusts and the relationship over the contracts, there are obviously thousands and thousands of contracts going on, sometimes between

hospitals, sometimes between the manufacturer and the homecare provider. To ask the question again: do you honestly think that local trusts have a clear line of sight of which contracts are being defaulted on? Are there penalty clauses? How are these contracts drawn up? What is the reality of the state of play at that very granular local level?

Will Quince MP: David is probably a better person to answer that. The answer really would lie with chief pharmacists as to how empowered they feel to the management of the contracts.

David Webb: Thank you. I think it is true to say that there is quite an amount of variability in hospitals as to how much support the chief pharmacist has to manage those contracts. For example, where the pharmaceutical industry uses multiple providers, you might end up with the same medicine requiring several contracts, depending on which provider has been selected. There is an important point about variability and the resource that is devoted to address that.

There is clarity for chief pharmacists regarding their responsibilities for the process with the Royal Pharmaceutical Society standards in relation to homecare medicine. There is direction and support regionally but variation locally as to how much resource is made available to make the management of those contracts as slick as it should be.

Baroness Bertin: There needs to be data, which also helps patients escalating where it has gone wrong. In certain cases, the patient will not know where to begin. That is ultimately the big issue, as the Chair raised at the beginning. That is not really a question; it is an observation.

Will Quince MP: I agree. On many of these issues, having not just clear KPIs but transparency on the data so that trusts can be held to account is very important and something we need to look at.

Baroness Bertin: My final question is about chief pharmacists, so perhaps more for you, David. What options do they have to exercise their responsibilities in this area?

David Webb: They have been more limited recently because of incumbency of the contract; moving a contract from a homecare provider, where you have concerns, to another one is a significant amount of effort. A risk assessment is needed. In moving the contract, you may create risk that was not there before for patients who had a reasonable level of service provision.

There is not a huge amount of choice over where you might move, but there are levers over the contracts themselves and the ability to call forward the homecare providers to a meaningful discussion about the experiences that patients are having, and the resolution for some of those issues. Is it delay in delivery? Is it that the homecare provider is having trouble accessing the medicine and, therefore, to provide it to the patient? The framework for pulling people together to have those conversations is part of the contractual arrangement. The ultimate sanction about moving is more limited by the availability of homecare

providers. In most instances, you are trying to improve the service rather than switch it to a wholly new provider.

Q55 Lord Willis of Knaresborough: There are two things. First, the 61 KPIs are the current national KPIs. There are other massive KPIs that are regional and relate to individual trusts, so it is not just that; it is a massive programme.

The question I want to ask, Minister, is this. We were struck by the idea that pharmacy is clearly the key element. I ought to say that, since we last raised it, I have become a member of the service, because I am now getting treated for pulmonary fibrosis on a national basis, so I have a vested interest in getting this right for the next 20 years, please God. Pharmacy seems to me to be so crucial and yet we did not feel as a Committee—I think I speak for the whole Committee—that either the chief pharmacist or indeed the regional chief pharmacists had sufficient responsibility and power to ensure that the system works efficiently and effectively.

Surely, the contract arrangements should always come through the chief pharmacist and his colleagues, so that you have a single organisation that runs the whole thing and enables you, Minister, to link into local pharmacy services as well, which are increasingly being very effectively put out to patients. We did not see evidence that those two things would come together, and they will not come together unless your colleagues have the power, responsibility and accountability to do it.

Will Quince MP: I broadly agree with all of that, and I hope that as part of NHS England's desktop exercise it will be able to look at exactly that. I do not know whether either of my colleagues want to add much to that.

Lord Willis of Knaresborough: Just say yes, David.

David Webb: Concerns were raised with us by the British Society for Rheumatology in advance of the Committee's work. We met it and had already started thinking about the desktop exercise to understand how the governance and accountabilities flow. We are minded to move in a fairly concerted direction. One reason why we are not going straight to a large-scale review is that we think that some things can be done more quickly that would help to address the issues you have encountered.

Lord Willis of Knaresborough: Unless you do that, and have KPIs that do not reflect the national scene, surely you are just creating more problems for the future.

David Webb: The National Homecare Medicines Committee is consulting on those new KPIs as of next week. I can certainly advise the Committee.

The Chair: This is a crucial area. If I were the Minister, the real question would be how radical you are going to be. How much more evidence do you need that there is a major problem? Why are you doing a desktop inquiry to find out what needs to be done? If you really think that the next step is small changes to make it a bit better, I am really worried.

Will Quince MP: I do not think that is the case.

The Chair: It is suggested that that is happening.

Will Quince MP: As a starting point, yes, but it will not take very long, David, will it? The only slight pushback I have is that you all know how departments work. Where you have arm's-length bodies of this nature, a concern will be flagged and will then go to NHS England and Ministers. As a result, that puts it on our radar and it gets the attention it deserves. The committee's report will be hugely valuable in informing that work.

The evidence presented to the Committee is conflicting and mixed. As a result, we have to look into that at a level of detail before just jumping in. Looking at the evidence so far, things like agreed KPIs, transparency of returns, an interoperable e-prescribing service and greater support for pharmacy teams at local level are all things that, without needing to see the paper-based exercise, I know we need to get on with and do. Nevertheless, a lot more has been brought up. You can jump at these things, but it is more important to take a little bit of time to get it right. My understanding is that the plan is to have the paper-based exercise concluded towards the end of this autumn and early next year, so we are working at pace. In health terms that is at pace, because we have to get it right, but I think that paper-based exercise is the important first step.

Q56 **Lord Bach:** My question is more about ministerial portfolios. You have a huge portfolio, Minister; I imagine all Health Ministers have. What I cannot understand—maybe because I am a simpleton—is how your portfolio, where you are obviously in charge of the homecare medicines service when the issue arises for the department, is a separate portfolio from that of Mr O'Brien, who is the Minister for pharmacy for these purposes. Do you have any thoughts about how sensible it is, when pharmacy, I think we all agree is such a crucial part of what we are discussing, that two Ministers, one more senior than the other—I appreciate that—have these particular things in their portfolios? Should they not be brought together?

Will Quince MP: It is a fair question and, in truth, ministerial portfolios overlap in so many areas.

Lord Bach: I was a Minister once.

Will Quince MP: Apologies for not being aware of that. As a result, we inevitably work closely with the rest of the ministerial team. You may not be aware of this, but I think that our Secretary of State was the first in Whitehall, in effect, to abolish ministerial offices. We all work open plan on one floor; all Ministers sit together with special advisers and senior civil servants on the same floor. I sit closer to Minister O'Brien than I am sitting to you now. That means that we speak every day on these issues, likewise with Minister Whately, Minister Caulfield and, of course, the Secretary of State, who sits with us too. I agree with you, but I do not think that it is in any way an impediment to what we do. Ultimately, we do not run these services; we set the strategic direction and come in and

hold NHS England and others to account, because we are accountable to Parliament.

Lord Bach: Perhaps the two of you will discuss in the future, if you have not already, the issues we have raised this afternoon.

Will Quince MP: We certainly will.

Lord Bach: I think a bit of ministerial bounce would be useful.

Will Quince MP: Yes. Mr O'Brien is working very closely on the broader area of Pharmacy First and, as was alluded to, far greater use of community pharmacy, which is a huge untapped resource that is massively trusted by the public. It would make no sense not to undertake this work in association with the work he is doing on community pharmacy. I totally agree.

Q57 **Lord Carter of Coles:** I suppose my question touches on the strategy point we were just raising, because it is clearly a departmental responsibility. It depends on the number, but I suspect that home care is about 3% of the whole NHS budget, whether it is £3 billion or £4 billion. Looking at the way it is going, I would not be surprised if it went to 5% within 10 or 15 years, given government policy to move more to home care.

My question is about whether you have the necessary infrastructure and resources to do it effectively. Clearly, there are questions at the moment. The service has grown rather exponentially, and it still feels like it is a very bumpy growth phase in terms of the processes and things to manage it. There are three things we would like to examine with you. I am glad that Mr Singal is here, because he is just the person we need.

On the question of interoperability, we had a lot of evidence from users and so on about just how clunky, paper-based and prone to error the system is. We know that NHS England has a great many challenges in the whole electronic area. Building on that, e-prescribing in community pharmacy is now going well. It was slow, but I think it has gone well. Do we have enough homecare experts to deal with the growth that we all feel is coming?

Minister, I do not know how you would like to deal with the interoperability question. I would preface it by saying that my own experience of pharmacy in the National Health Service is that it is one of the most excellent services. It has responded to the challenges, taken out cost effectively, restaffed, deskilled and done many things effectively. I wish I could say the same about NHS IT, which has not been quite such a dazzling success.

Perhaps you would like to help us understand where you think the department thinks its policy is on interoperability. We can then perhaps go into the detail of how that will be delivered, go on to e-prescriptions, and perhaps spend a couple of minutes at the end on resources.

Will Quince MP: Again, it is complex, but it seems to me that interoperability is a key area on which we need to focus. Perhaps I will hand over to Rahul and then come back to talk about workforce in a bit more depth.

Rahul Singal: We can look at interoperability in the scope of the broader interoperability of IT systems. If we look at the flow of medicines information and the scope of medicines interoperability, we have probably made huge progress on that front, and we have what we call a medicines interoperable standard that was published about three years ago and an ISN that accompanies it. What that standard has done, as well as the progress that has made over the years, is to have consistent terminology for what all medicines are across all systems and agree a common standard. The real challenge is the adoption of that standard in and among the multiplicity of suppliers, providers and IT systems that we are talking about.

In the medicine space, we have made huge progress in achieving the core foundational standards of interoperability. The challenge at the moment is adoption across the multiple suppliers that we have heard about today. There are NHS IT solutions, different pharmaceutical companies and different homecare providers, all of which operate with different IT systems. Our challenge is the adoption of common standards across those suppliers, which would probably achieve what we are talking about on common interoperability.

Lord Carter of Coles: Is there a standard? If you contract with the National Health Service in England, are you required to agree to implement those standards and to contract? Is it a question of unwillingness or inability on the part of those people? Why are they not doing it?

Rahul Singal: The mechanism we use to set standards and to ask providers to do that is an information standards notice, an ISN. We have done the work to publish that, and it had a compliance date of March this year. That is not just for the scope of home care but for the scope of all clinical systems that operate with medicines.

To your question about why it has not been adopted, there is a broader challenge, which I guess is being discussed, in the digital transformation space around the adoption of ISNs and how effective they have been, and what levers there are, but the ISNs are towards NHS trusts. It is similar to what we have been saying here about how much power and how many levers an NHS trust has in enforcing those ISNs with their suppliers. That is the challenge we have at the moment.

Lord Carter of Coles: I do not want to dwell too much on this, but would I be right in saying that actually it is not happening because we cannot do it? We know what to do, but we cannot do it.

Rahul Singal: It is fair to say that we have probably done the part nationally to agree the standard and do it, but the challenge is the adoption.

Lord Carter of Coles: Minister, I wonder if somebody could write to us and tell us when they think it might happen, given all this. When might we as users have a sense that the interoperability is established, that there is a common code, and whether it is one year, two years, or five years? We will come back to the resources question.

Will Quince MP: We can certainly commit to that. The question of people, given the figures I quoted earlier, will be one of the biggest challenges that we face. More people, understandably, want to be treated and stay at home wherever possible. I would, too. It is, broadly, something we should welcome, but it brings with it challenges.

You will have seen a significant expansion of hospital at home or virtual wards, which are hugely popular with patients and going very well, but it means that the workforce over time will change and shift, and that is very much reflected in the NHS long-term workforce plan. It is likewise with pharmacy and the number of pharmacists we need, especially as more and more are working in multidisciplinary teams in general practice and other areas as well as in community pharmacy. It is something we are very much alive to.

The only thing other thing I would say about the long-term workforce plan is that, although it is a long-term workforce plan that looks at the next, five, 10 or 15 years, it will be reviewed every two years to make sure that we are actually on top of some of the changes in the provision of medicine and healthcare.

Lord Carter of Coles: Thank you. Bringing that together, because it is a diverse system, presumably there will be parts of the country where, even given all these handicaps, people are doing jolly well, and there will be other parts of the country where people are finding it quite difficult. If this Committee wanted to make a visit to see something that worked really well, could somebody write to us and suggest three areas of the country where in the view of the chief pharmacist and the technology department, and in your own view indeed, there is something of an exemplar that we can understand and perhaps hear from them about what the challenges are? Would that be possible?

Will Quince MP: We can certainly do that. Three is probably wise, because the data can sometimes be misleading. You can look at London trusts where the demographic is very different from Suffolk or north Essex, which have a large elderly population.

Q58 The Chair: There is one thing we have missed out in our discussion. I do not want to keep you longer than we said, but we have not talked at all about the regulators, and that was a big issue in the evidence that we have had. To be honest, we are not impressed with what is happening with the regulators, because no one seems to have an overall view of the

regulation and can take action.

There is more than one regulator and 7.5 million people. It is not as though it is serving 52 million. At the moment, all this complexity is wrapped around a relatively small but growing number of people. When we spoke to the CQC, it said: 'We're all looking at different aspects of—home care—there is no one saying overarchingly, 'This provider is not doing this and this''. The CQC does not regulate all providers, as not all providers provide a "regulated activity" under the Health and Social Care Act. Then we have the General Pharmaceutical Council as well.

Our summary was that the regulation is not working. My impression was that the CQC underestimates the nature of the problems out there. I think it is really complacent, and that is of concern. One of the issues we raised with it was the thematic review. It seemed to us that it was, 'To do things quickly, do a thematic review'. The CQC said it cannot do that without your permission, apparently, which surprised us and did not please us. We wondered if that is something you have thought of. For the last five, six, seven or eight minutes, could I open a discussion on the regulators and your view as to how that is going?

Will Quince MP: Certainly. The honest answer about the CQC is that I do not know, but I will take that away and look into what is within the art of the possible.

Homecare medicines services operate in a highly regulated environment, but it is important to separate two things: the regulated activity of statutory oversight, which the CQC does for regulated activities, and broader performance management, which is an issue for the chief pharmacist and the trust. I certainly understand that it is a complex picture. The evidence to the committee that I have seen suggests that there have been numerous and regular inspections by the CQC, and concerns have been raised and improvement actions have come as a result.

One of the big changes that is coming imminently is the move of the CQC to the single assessment framework, which will mean that instead of having a single assessment, as in a rating, it will be able to act in a more agile way, with the inspections being less routine and more ad hoc, and I think that will make a difference. Nevertheless, if we need to look at regulation again, based on the evidence presented to this inquiry, as part of NHS England's work, I would expect nothing less than that being done.

Lord Willis of Knaresborough: The CQC said that it cannot do that even if you wanted to do it, because it would be in conflict with the 2008 Health and Social Care Act. It said that it cannot do anything outside the prescribed elements unless, in fact, it refers back to that Act.

Will Quince MP: That is true. It has to be a regulated activity that it would inspect. That is my understanding. David?

David Webb: Yes, correct.

Lord Willis of Knaresborough: That seems to be the problem: where

there is something that is a little ad hoc and requires bringing in different parts, suddenly they cannot do it. It is very frustrating for the committee to have them say, 'Sorry, but we can't do it'. It is not good enough.

Will Quince MP: I do not disagree. This is an area that we clearly need to look at as part of the review.

Lord Laming: Could you respond to the Chair's question? Maybe I misunderstood the CQC, but it seemed to me that its evidence was, 'Unless this comes as a request from the Minister, we can't take any action in our own right'. I must say that something like that coming from what seems to be an independent regulator struck most of us as pretty astonishing. If you were able to say to us, Minister, that that is a complete misunderstanding, it would be some comfort. If you were to say that what the CQC gave us in evidence is right, I think we would be pretty astonished.

Will Quince MP: It was not my understanding, which is why I will go back and make sure that we clarify that, and I will write to the Committee with the exact position.²

The Chair: Okay. I really do not want to keep the Minister longer than the hour because he has had a very disrupted afternoon anyway, but is there any key last question that will take one minute to both ask and answer?

Q59 **Lord Shipley:** Could I ask about the status of this Committee's report? David Webb told us that there was a desktop exercise and perhaps more pending, but I am not clear what the timing of that might be. There is clearly a range of issues that need to be addressed. Is it the case that you are actually waiting for this committee to report, or is the work that you are doing self-contained and does not really need this committee's direct input? Clearly we would influence, maybe, but are you waiting for us to report to decide what to do?

Will Quince MP: With respect to the committee, we are not waiting, because we have seen and have had access to the evidence. Nevertheless, your report will be hugely valuable in informing the work that the team at NHS England is doing. Its plan is to have completed the first stage, which is a desktop exercise and discussion with relevant

² The Department of Health and Social Care have clarified that the CQC may conduct thematic investigations without an instruction from the Secretary of State. Section 48 of the Health and Social Care Act 2008 enables the CQC to conduct additional reviews and investigations (referred to as 'special reviews and investigations'). Section 48(2) sets out the areas that these special reviews and investigations can cover: the Commission could look specifically or generally at any issue to do with different kinds of health or adult social care, including the commissioning of that care, how particular functions are carried out or provision by particular people or bodies. Investigations may be carried out where the CQC identifies a risk to a care recipient's health or welfare. For instance, the CQC might investigate older people's services in a particular area, and then nationally where there is evidence to suggest a problem is more widespread. The Commission may also carry out reviews into topics of particular interest, for instance, it may carry out a review of care pathways for people with long-term conditions. Separately, the Commission must carry out a particular review or investigation if requested by the Secretary of State.

stakeholders, by the autumn. I cannot give you a timeline for the second stage, because it will depend on the recommendations of that desktop exercise. I would have thought that the timing for when this inquiry's report is about to come out will be pretty spot-on in terms of the work of NHS England in this area. It will be very timely.

The Chair: We hope to have it after the King's Speech.

Will Quince MP: I certainly commit to keeping the Committee updated with the work of NHS England in this area.

The Chair: Minister, I thank you, first, for coming, but mainly for your approach. It was very helpful to us that you acknowledged that there is an issue. I do not think I have been on an inquiry where there has been such shock among Members as to what we have found and such unanimity about the purpose we want to fulfil to help solve the problem. In all the committees that I have been on, that is desperately what we want to try to do, and we very much hope that the report that we publish helps you in that.

You are right that there is conflicting evidence—that has been one of the great frustrations—but if you look at it, the conflict is between those who run the service and those who receive the service. There is no conflicting evidence among those who receive the service; there is unanimity that it is awful. There is no conflict among those running the service; there is unanimity that it is all fine. That is the problem. Could you bear that in mind? I am sure that in the past I have used conflicting information as a reason not to take action. We are very grateful, and it is our intention to revisit this at some point, so we hope that we may build up a partnership with your officials and can be as helpful as we can. Thank you very much.