HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Pharmacy, HC 140

Tuesday 21 November 2023

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Watch the meeting

Members present: Rachael Maskell; Paul Blomfield; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; James Morris.

In the absence of the Chair, Rachael Maskell took the Chair.

Questions 1 - 58

Witnesses

I: Malcolm Harrison, Chief Executive, Company Chemists' Association; Jay Badenhorst, Vice Chair, National Pharmacy Association; and Dr Leyla Hannbeck, Chief Executive, Association of Independent Multiple Pharmacies.

II: James Davies, Director for England, Royal Pharmaceutical Society; and Dr Graham Stretch, President, Primary Care Pharmacy Association.

Examination of witnesses

Witnesses: Malcolm Harrison, Jay Badenhorst and Dr Hannbeck.

Q1 **Chair:** Welcome to the first session of the Health and Social Care Select Committee looking at pharmacy. We are starting our new inquiry today. I am Rachael Maskell, vice-Chair of the Committee. Our Chair is indisposed; we wish him well in his recovery.

Today is our introductory session, where we will look at some of the key themes impacting on pharmacy, both in the community and in hospital and general practice. We are pleased to have two panels today. The first panel is looking specifically at community pharmacy, and then we will move to hospital and general practice. We shall be hearing some of the challenges and some of the vision for the future of pharmacy, and actions that the Government and NHS England can take to address those challenges and prepare for the future, as well as looking at some of the big themes coming out around workforce, technology, automation and organisation contracting. There are many different areas that we want to drill down into.

I am really pleased to welcome our first panel. Malcolm Harrison is chief executive of the Company Chemists' Association in England, Scotland and Wales. That co-ordinates some of the big players like Boots, Asda and other retail outlets. Jay Badenhorst is vice-chair of the National Pharmacy Association, which oversees the independent community sector of pharmacy. We also welcome Leyla Hannbeck, who represents and is chief executive of the Association of Independent Multiple Pharmacies. That is where there are two or more pharmacies in our communities.

Welcome everyone. We will start with an opening question for you all just to set the pace. Are the Government ambitious enough in what they believe community pharmacy can do, particularly to address NHS pressures at this time, or are they being held back by issues around workforce, funding, contracting and other technological changes?

Malcolm Harrison: Good morning, everybody. Are the Government ambitious enough? I don't think so. There is always opportunity to be even more ambitious. We have recently seen the announcement of additional funding to allow community pharmacies to do more to help with primary care, which is really exciting. We are keen that community pharmacies are able to help patients to access primary care in the best way possible. However, there is more that community pharmacies can do. The current plan is for pharmacies to be able to take on about 10 million to 12 million GP appointments a year. Our research in 2022 showed that community pharmacies could easily take on about 42 million GP appointments. There is still a huge upside to go in what community pharmacies can do.

The real challenge facing the sector, though, is that while there is new money available to deliver new workload, which is good, the existing workload—the 80% to 85% of what community pharmacies currently

do—is chronically underfunded. There is a risk that the ability to deliver for the future will be impacted by the ability to deliver for today. What we are really calling on the Government to do is to be realistic and more ambitious with what they want us to do in terms of the supply function and the core function of community pharmacies, so that we have a solid foundation to build on for the future.

Q2 **Chair:** Leyla Hannbeck, do you agree with that? Could the Government be more ambitious?

Dr Hannbeck: Of course, there is much more room for being ambitious. I would like to start by highlighting that earlier this year, we presented data to the Treasury on the state of community pharmacy and the fact that our sector is currently short of £1.2 billion in its core funding. Unless that shortfall is addressed, many community pharmacies will struggle to keep their heads above water. In many communities, many are actually shutting their doors for good.

They are suffering because of the fact that many of them are heavily in debt. They have to raid their pensions and personal funds to be able to pay the higher rents that have been rising with inflation. They have higher costs for energy and everything else. There is definitely room for Government to support us. We have always been very open with the Government that if community pharmacy is supported and funded appropriately, we want to be there as a solution. We have already demonstrated that during the pandemic. We kept our doors open, and we kept going and supported the public. That could happen very well, but we have to have the support and funding to be able to operate.

Q3 **Chair:** Thank you. Jay Badenhorst, you represent small providers in the sector. What are the big challenges that your members say they are facing?

Jay Badenhorst: Thank you very much for letting me speak. Could I note that we do not just represent the small ones? We have larger members as well, so there is a lot of overlap. However, I think the challenges that we face as single, independently owned pharmacies are probably exactly the same as for the larger ones. As my colleagues were saying, the ambition is great, but at the moment the challenges are greater for all pharmacies. That is demonstrated by the attrition that we see in pharmacy numbers. Many pharmacy groups and independently owned pharmacies are going up for sale because there is no way for them to operate further.

The funding challenges that we are seeing are specifically associated with core funding. My colleagues have already alluded to some of the numbers flying around. It is fair to say that our negotiating committee, Community Pharmacy England, needs to do its job in order to negotiate the funding associated with our core function. Depending on which calculations you look at, that would be anything from £600 million if community pharmacy received the same funding increases that the other parts of the NHS have

received. If you then include all the inflationary increases and all the other increases that we have seen, it rises to about £1.25 billion. There are a lot of numbers flying around and we are not the only department crying out for money. There is no magic money tree that we can just pluck money from. We absolutely recognise that.

The ambition for pharmacy is really great. Seeing the £645 million that was announced recently would definitely be a step in the right direction. That is new money for new services and is really good because it will address the need going into the winter. The ambition for bringing that forward should be noted. It is only due to start in February. The winter pressures do not start in February; they start now. I know that there are certain delays we need to take into consideration, but it will be ambitious and very good if we can bring that forward and start it earlier to meet patient demand.

Our pharmacies are incredibly stretched at the moment. We face a massive issue with workforce due to various things that are impacting us. In the past, we were able to accommodate some of the increases, like the living wage increases. I am absolutely an advocate for people getting paid appropriately for the work they do, but with our core funding being flat, we cannot keep on taking the cost into the pharmacies because there is no additional funding coming our way for the existing core services that we do.

As I said, the ambition is great, but the challenges are greater. We need to go a step further to try to address some of the immediate needs in community pharmacy. If we do not—there are lots of studies out there already—there is a great risk that our very good and invaluable network of community pharmacies will slowly erode to a point when there will be a massive downturn. We could potentially see uncontrolled closures, which will then have a further impact on the pressures that we already face in GP practices and in the NHS and the wider sector.

Q4 **Chair:** This Committee is about making recommendations to Government, and we want to think about the policy space. With that in mind, staying with you Jay, and looking at the issues around funding that you have been talking about, with additional roles being provided for and core funding under challenge, is there a need to look at the contracting arrangements, to see that they move forward with the additional support that is required? If so, what would you want to see changing in the contractual arrangements?

Jay Badenhorst: It is a good time for us to look at the contractual arrangements that we have in place. We are coming out of a flat-funded five-year contract. There are already talks about the next year potentially being a roll-over year. I do not think that should necessarily be something that just continues rolling forward as it is, because there is very good evidence that it is no longer fit for purpose. It is definitely not keeping up with all the inflationary increases that we are seeing.

One of the things that we are very keen on at the NPA, and which we have demonstrated in our vision document, already provided, "Making Changes Meeting Needs", is looking at local commissioning opportunities. There is definitely a need for a nationally agreed contractual framework to deal with the bulk of the work that we are doing. There is definitely opportunity for us to look at local devolution arrangements, where the ICBs can potentially take on some of the contractual commissioning purposes for community pharmacy. For example, something like the ARRS money should be open to community pharmacy as well. We do not want to see that closed. We want to see it expanded so that we can look at how we can meet the challenges, not just in a small part of the contract but by looking more widely at community pharmacy playing a part in primary care. That would potentially direct patients to community pharmacy, where we already have pharmacists working and doing portfolio work through an ARRS-funded model. We can definitely look at what is delivered nationally and how we can streamline that and make it really efficient for taxpayers' money, and meet population health demands that are not necessarily appropriately met by nationally agreed contracts. That has to be at ICB level.

Q5 **Chair:** Thank you. Leyla, what would be your priorities with regard to a call on Government at this time?

Dr Hannbeck: If you look back at the NHS long-term plan, which was published in 2018, prevention was one of the key points that they wanted to raise. Accessibility to care in communities was something that they were talking about. Those are the domains of community pharmacy. We are accessible. Patients can walk through the door and speak to a healthcare professional. We can play a big role in the prevention agenda, keeping people from ending up in hospitals and A&Es.

Our contract needs to be reviewed. It is not fit for purpose the way it is now. It is way too complicated to navigate around. A lot of times, when I speak to politicians such as yourselves, people are struggling to get their heads around community pharmacy contracts. It does not have to be so complicated. It just needs to be based on the fact that you have a workforce right at the heart of communities and part of the very fabric of people's lives that could play an incredible role for your constituents to make sure that we prevent ill health in people, keep them living longer in their own home and make sure that we provide the accessibility that so many people, particularly the elderly and those with young families, appreciate. Our contract needs to be reviewed. That is something that needs to be started from scratch, Chair.

Q6 **Chair:** Briefly, Malcolm Harrison, do you concur that the contracting and funding interface needs review at this time?

Malcolm Harrison: I am not sure that review is enough, to be honest with you. We have been quite clear that it is broken. It is not just that it is not fit for purpose; it is completely broken. The current contractual arrangement was first agreed back in 2014. That was the last time there

was any increase in funding available to pharmacy. Since then there has been a real-terms cut of over 30% in funding for community pharmacies. In 2016, £200 million was cut from the budget, and ever since then we have seen continual top-slicing of the money that was used to pay for the supply of medicines, which is the core function of community pharmacy. Pharmacies have been asked to earn that money back again by doing new and additional services. We are now at a point where NHS work does not pay. I think my colleagues have already suggested that a lot of businesses are now struggling to make any money and are having to close.

A review is probably not enough. We need to look at the core principles and what the NHS wants community pharmacy to do and how much it can afford, and then make sure that the two meet. Since 2017, we have seen an increase of 10% in the number of items that the NHS is prescribing, but no increase in what they are paying for that. Unfortunately, community pharmacy works in a monopsony; there is only one buyer, which is the NHS. I do not think that the way it has approached the remuneration model for community pharmacy is fair or in the interests of the taxpayer when we see continual erosion in the service that members of the public can obtain.

Chair: Thank you. I will hand over to my colleague, Paul Blomfield.

Q7 **Paul Blomfield:** Thank you, Chair. I want to press a little further on the issue. In advance of our session, I talked to one of our longest-serving community pharmacy providers in Sheffield. He made the point to me that we are now reaching a tipping point where a significant number of community pharmacies will close in the next 12 to 18 months without a cash injection. He argued that those who had invested most in premises, equipment and staff training were the most exposed. He talked about the unviability of the extended hours service, going forward. Does that picture reflect the situation as you see it?

Jay Badenhorst: I think I know who you are referring to: Martin Bennett from Wicker Pharmacy. Martin has been a beacon in pharmacy for many years. I have also spoken to him recently and I absolutely echo what he is saying.

In my other life, I work as superintendent pharmacist for a company called Whitworth Pharmacy, independently owned by two family members for 57 years. We are celebrating this year. Unfortunately, this year it has got so tough that our whole pharmacy group is on the market at the moment, including our pharmacy in York. For me, it is a turning point and it is demonstrated by internal and external pressures coming to boiling point. Unfortunately, for a lot of independent businesses there is no way out but to sell. All of a sudden, if everyone starts selling because of the pressures, it will bring a lot of instability to the market. Ultimately, patients will no longer know where to turn.

Earlier, we said that if the network is not sustained and appropriately funded, and at some point that network is not there any longer, we are not going to get it back. Once it has gone, our invaluable asset doing very good public services will be gone. What Martin described to you is absolutely crucial. We have to try to get back on to a level playing field, where pharmacy can provide the services that patients want and that the NHS wants to commission to us. It is crucial that we get that balance right for taxpayers' money, and for the contract to be sustainable enough to carry on serving patients locally.

Q8 **Paul Blomfield:** I assume that Leyla and Malcolm would agree with that broad assessment. I want to move to what a better funding model might look like. Jay, could I push you on one point? Earlier, you said that we ought to move to local commissioning. Where do you see the benefits of local commissioning? Is it just that ICBs would have the opportunity to pull money from somewhere else and put it into pharmacy?

Jay Badenhorst: Possibly not. There is a fine balance in a nationally agreed contract implemented locally in order to deal with population health. We could have a framework to try to address the nation's health needs through different services, whether NHS or otherwise. For example, we have a pharmacy in Middlesbrough. The population health needs in Middlesbrough are vastly different compared to the population health needs in York. If there are two different pharmacies in those two areas, there should be an opportunity to meet the population health needs in that specific locality. That is better done at an ICB level or within a place model. I do not think it necessarily means moving money from one to another. Both should be appropriately funded in order for us to deliver the needs of the population in the area.

Q9 **Paul Blomfield:** Local commissioning would enable money to be used better, but it would not necessarily solve the funding crisis that you were describing.

Jay Badenhorst: I agree—yes.

Q10 **Paul Blomfield:** Leyla, you said that the system was just too complicated, and we ought to have something far simpler. Martin argued that we should go back to the cost-plus contract. What is your vision for what a simpler system might look like?

Dr Hannbeck: If you look, for example, at the whole medicines reimbursement mechanism, it is way too complicated. The Department has made it so complicated that a lot of pharmacies find themselves out of pocket for sourcing medicines. For example, you wake up one day and see that the cost of antibiotics has gone up. On that day you are not prepared, but you have to pay that price because you want to get antibiotics for your patients. It takes a long time before the Department then negotiates a price increase so that contractors, pharmacists, get the same price that they are paying. It is a very complicated system, and it leaves a lot of our members, particularly independents, out of pocket.

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One thing I want to make sure I mention is that over 90% of our members' activities—pharmacies—are NHS activities. They cannot fall back on health and beauty products, groceries or anything like that. Everything that they do is NHS. If the NHS makes it way too complicated for pharmacies to be able even to pay their wholesalers' bills, it just shows that it is not fit for purpose. No business should be waking up in the morning not knowing what is going to happen today and asking, "Am I going to be able to survive until the next day because I simply cannot source the medicines because they are too expensive?" It just shows what Martin was saying—I know Martin well; it just is not fair.

May I say one more thing? In order to achieve change, we need to bring about cultural change in the top line of NHS hierarchy and the way community pharmacy is viewed at the top. Unless those cultural changes come into force, it will be very difficult to achieve any change anywhere.

Q11 **Paul Blomfield:** Malcolm, what would your funding model look like?

Malcolm Harrison: As I mentioned earlier, what we have not seen is an evolution of the current model for many years. The current pot available to pharmacies to source medicines for the NHS—over 1.075 billion items a year—has not changed in the last 10 years, even though the number of items has gone up and the cost of medicines has gone up. The allowable margin that community pharmacies can make has not changed. What we are seeing is a continual squeeze at the margin.

We have a situation now where the model we currently have is predicated on continual downward pressure on the cost of medicines. Medicines are getting cheaper and cheaper. Over the last 10 years, community pharmacies have saved the taxpayer and the NHS about £1 billion in the way they purchase generic medicines. We are a really valuable source for getting great value for the public, but that can only work until you get to rock bottom. You cannot buy medicines for naught. You have to pay for them. What we find now is that manufacturers say that there is not enough money in the market in this country and they are better off selling their medicines elsewhere in the global market. As my colleague said, that bumps up the price because there is a shortage. We then end up with it kangarooing around, so that manufacturers exit the English market, the price goes sky high because nobody can get hold of any and then manufacturers come in again and the price goes down. It is in and out, in and out, and it means that it is very difficult for businesses to understand how they are going to be able to move forward.

We need to review it. We need a simplified and more stable model that allows businesses to understand what their cash flow is going to be. We are currently in a situation where businesses are critically worried about January because of changes that were made to the drug tariff last February. A drug called apixaban has come off branded form to a generic form. The price has dropped significantly and adjustments have been made, rightly so, but they are so retrospective and it is so unclear where that is that businesses cannot forecast where they are going to be, come

the new year. We are going to see a huge impact from the changes. The actual physical change happened in February; the change to the tariff was made in October; and the impacts on contract will not be felt until January, but they are going to be massive. As my colleague said, how can you run a business in that way? We really need to simplify the model. We need to make sure it is fit for purpose today and for the future, not for 10 years ago.

Q12 **Paul Blomfield:** Later in the inquiry we will come back to look at drug pricing. The sort of volatility that you have described, in prices going both up and down, is difficult to build into a funding model, isn't it?

Malcolm Harrison: I think the drug pricing you will be looking at is VPAS, which is branded medicines and so on. What we are talking about is the generic market. You are absolutely right that it is very difficult to build in, but when you continue to squeeze something, eventually something has to give. What we have is a situation where the squeeze on the price of generic medicines—the unbranded medicines, the vast majority of medicines that the NHS prescribes and that pharmacies supply—has got to the stage now where it is completely unstable going forward. As I said, we are seeing manufacturers exit and enter, exit and enter, and some of them permanently exit, which causes real problems.

What this Government need to understand and need to be clearer on is that medicines are not manufactured and sold in this country. There is a global market for medicines, in both manufacture and purchase. When you find that manufacturers say that they are going to make more money selling those medicines elsewhere around the globe, we need to think in this country. We talk about energy security and so on. Medicine security is definitely something that we need to start to consider more.

Paul Blomfield: Thank you very much.

Chair: It is worth noting as well that Community Pharmacy England will be coming in, so we will obviously explore those contract issues in greater depth. Indeed, the Minister will be invited at the later stages of the inquiry to get that national perspective. I will bring in my colleague, James Morris.

Q13 **James Morris:** Mr Badenhorst, you refer to some of the workforce challenges that the sector currently faces, particularly issues around the additional roles reimbursement scheme. I want to understand a little bit more from you about what impact you think that scheme is having on community pharmacy.

Jay Badenhorst: I can talk from first-hand experience as superintendent pharmacist for the organisation that I work for. Until about a year and a half ago, we were fortunate enough to have pharmacists working permanently in all our pharmacies. When the ARRS scheme was announced, a lot of our pharmacists decided that to pursue their next career move or portfolio work, they wanted to leave community pharmacy to go and work in GP practices and PCNs in a different sort of

role. We are currently running about a third of our pharmacies without a permanent pharmacist.

It has a massive impact on continuation of care if a patient comes in and does not see the same pharmacist day in, day out. Of course, they need holidays—

Q14 **James Morris:** How are you dealing with that?

Jay Badenhorst: We need to get in temporary staff. We rely on locum pharmacists to come into the pharmacies. Don't get me wrong; some of them do an incredibly good job. We also have staff who do an incredible job. There are lots of technicians and dispensing staff as well, so there is some element of continuation of care. Some of the services delivered in a pharmacy can only be done by a pharmacist, and if there is a local relationship between a patient and a pharmacist, the outcomes are so much better.

Instead of stopping the ARRS money, we should open it up and allow community pharmacy to play a part as well. That would inevitably cause the pharmacists we employ to stay in position and expand their role in community pharmacy rather than having to step out of that role into another role. For me, that is more like migration and not integration. Integration is about having everyone with equitable access to all of the funding, so that we can all play the same part in the global health system within the UK. Isolating a funding source into a silo means, unfortunately, that the workforce are moving from one silo into another silo rather than opening it up and people working together.

One of our best pharmacies in the company I work for has actually got two pharmacists in place. It is a phenomenal pharmacy in County Durham. One pharmacist is an independent prescriber; the other is at the very top of his career as well. For me, that is the ultimate way we want to go, where pharmacists are visible in pharmacies in order to deliver the expanded role that the NHS wants us to do, not forgetting the core function. Of course, we have to do that as well. The services have now expanded into much more than just the supplying of medicine. If we do not have a regular pharmacist in the pharmacy, I think there is a real risk that we start losing out on patient care.

James Morris: Leyla, do you want to make a comment?

Dr Hannbeck: Over £380 million has been spent as part of the ARRS scheme. I mentioned before that there are some cultural changes needed within the NHS hierarchy. The issue is that when the ARRS scheme came out, we, as a sector whose workforce ended up leaving to go to GP practices, were never consulted. It was something that landed on us without any discussion or any forewarning that it was going to happen. Had there been discussions with us, perhaps we would have had the opportunity to say, "Look, if you invest in community pharmacy, we are very accessible. We get 1.6 million people coming through the door. We

can very well host a multidisciplinary team in the community pharmacy environment and deliver those sorts of services to pharmacies." The scheme created the lack of a level playing field for our sector.

There are certain challenges in community pharmacy—for example, our opening hours and the fact that, as a pharmacist, I am standing for most of the day and working behind a counter without the opportunity to sit down. The pandemic opened up the whole thing about working from home and flexibility, which was attractive to other people. Based on the regulations that we currently have, those were luxuries that we could not afford in community pharmacy, so our workforce ended up leaving. If you add the lack of funding, it boosted that and created a terrible thing for us.

Q15 **James Morris:** Mr Harrison, do you have anything to add?

Malcolm Harrison: This is a case of unintended consequences, if I might propose that. In an attempt to fix one part of the system, which was the shortage of GPs, the Government and the NHS found a lot of money and created a lot more roles for pharmacists in general practice. That is brilliant for the patients who need to see a general practitioner or need to access primary care there.

The problem we had, though, was that there was not a good understanding of the availability of pharmacists. They have created up to 8,000 new positions out there, but there were no extra pharmacists in community pharmacy. There weren't pharmacists sitting at home thinking, "I need to do some work please, so can someone find a job for me?" They have robbed Peter to pay Paul. What we have done is created a resource in general practice, in primary care networks, which is fantastic for patients who need access there, but we have created a chronic shortage in community pharmacies.

What that has ended up doing is driving up the cost of pharmacists. We are now seeing both hospitals and community pharmacies very short of people. We are actually starting to see people leaving primary care, where they have gone for the new jobs, because they can earn more money as a locum working for Jays pharmacies in community. We have just increased the costs for the taxpayer.

Q16 **James Morris:** As a follow-up, the ARRS scheme may or may not have had unintended consequences, but are there any other factors impacting the workforce for pharmacy which are not related to that? Even if that scheme was to be opened up and changed, it is not necessarily going to be a silver bullet for transformation of the workforce, is it? Are there any other factors?

Jay Badenhorst: Yes, absolutely. One of the things I can talk very passionately about, unfortunately, is the impact on patients when they come into the pharmacy and experience a shortfall, with a pharmacist potentially not being available or the staff having turned over. There is anger and aggression that we sometimes have to deal with from patients.

I sense that frustration because they cannot have access to the healthcare that they deserve and need.

A very good example is our pharmacy in Barnoldswick, for example. Our pharmacist left as a result of being asked to go and work in another part of the NHS. Unfortunately, at the same time, because of the change, we lost our technician. We lost a very key person in dispensing as well. We had a load of new staff working in the pharmacy. Unfortunately, we then had to reduce the opening hours because we could not meet the need. We had to stop all advance services. It had a massive impact. We put people back in place and the pharmacy is now on a more level playing field, but we have to keep in mind how the public and patients will react if they cannot get access to care. In the same way that we see them reacting in urgent care when they have to wait for 12 hours, or they get very angry or shout at GPs when they cannot get a GP appointment, we face exactly the same. The problem is that we are in an open environment, and quite often they are violent towards our staff. There is a big impact there as well.

Q17 **James Morris:** Malcolm?

Malcolm Harrison: I think you asked about other factors. Even if community pharmacies were able to access funding from the ARRS, unfortunately, you cannot put the genie back in the bottle. Those roles have been created, which means that for a number of years there will continue to be a shortage of pharmacists.

What is really important is to recognise what we have talked about previously around funding. The continual squeeze on the funding available to community pharmacies means that they have not been able to invest in the way they would want to in their people, in their infrastructure or in the systems that they use and so on. An increasingly growing volume of prescription items from the NHS—the volume growth has been phenomenal—means that the workload pressure on pharmacists has been growing and growing. We have not been able to invest as much as we would like to support individuals in the pharmacies, and they are being asked to do more and more work. As I said previously, the top-slicing of funding that was paying them to do one job, while they were still having to do that and do other work as well, means that the environment has become very pressurised. It is not surprising that when a whole load of new opportunities is funded by the NHS elsewhere, people think that the grass will be greener.

Q18 **James Morris:** Leyla, are there any other factors that you think impact on the workforce, or have we covered it?

Dr Hannbeck: Since the pandemic, our workforce has been under a lot of pressure. We have been trying to recover as the months have passed, but obviously the ARRS scheme coming in has led to more exhaustion for our teams because you end up losing experienced pharmacists that many

of our patients know very well. Colleagues have mentioned that. A cultural shift is needed within the NHS hierarchy.

Jay Badenhorst: I have one point to add. One of the key differences between us and potentially other people working in primary care is the lack of protected learning time. For example, there is a £645 million scheme announced for minor ailments. It is absolutely brilliant, but quite often our pharmacists, technicians and people involved in that service will have to do training in their own time, at night on a Saturday or a Sunday, when a lot of other primary care organisations have protected learning time when they can almost go out of practice for a certain amount of time in order to upskill and deliver the commissioned services.

Chair: Thank you. Chris Green is going to explore hub and spoke.

Q19 **Chris Green:** Mr Harrison, the innovation cost savings are going to be key to the future of the pharmacy sector, especially as I appreciate the pressure in terms of costs. Why isn't the hub and spoke approach more widely adopted in the sector?

Malcolm Harrison: I suppose there are two reasons. Primarily, you currently cannot dispense across legal entities. You can only operate a hub and spoke arrangement within a legal entity, within a company. Companies that had the scale and the ability to invest previously—I will come back to that—were able to establish facilities that enabled them to move workload to free up capacity in the community pharmacies. As I mentioned previously, capacity has been a real challenge on the workforce in community pharmacies.

The interesting point there is about their ability to invest. The continual erosion in the funding available to community pharmacies means that they are no longer able to make those investment decisions. Even businesses that have hub and spoke arrangements, if you look at the volumes they put through and the ability to roll that out across their estates, have not done it because they cannot get the return on what they are doing and they cannot make it work.

Q20 **Chris Green:** Even though perhaps the current set-up lends itself because it is within one legal entity, even the large organisations find it difficult to do.

Malcolm Harrison: It doesn't save money. I have not come across a single business that operates a hub and spoke within their own organisation, whether they are some of the very large CCA members or even some of the smaller businesses who are able to use it. It does not save money. All it does is to move the workload. You can relieve the pressure in community pharmacies; you can create a bit of capacity for them to do other things; but they are reliant on, and we come back to this, the ambition of the NHS to commission services from them. You need new work for them to be able to do. If you are going to take the dispensing workload out of the community pharmacy, what is the

pharmacist going to do and how can we make sure there is enough work for them to maintain the pharmacy and maintain access for patients?

It is really important that commissioners and Government understand that hub and spoke is not a magic bullet. It does not save money. We have a situation now where, hopefully, the law will be changed to enable dispensing to be across legal entities, but if you cannot make it profitable dispensing yourself, in your own business, how are you going to be able to afford to pay someone else to do it for you? That is the situation we have got to.

Q21 **Chris Green:** Dr Hannbeck, I was going to start this by suggesting that with a little bit of up-front investment you might be able to make some savings down the line, but I think that point has been challenged now.

Dr Hannbeck: Yes. The equipment to run hub and spoke is expensive. The automation equipment is expensive to purchase and expensive to maintain because it needs replacing, it breaks and all of that. It is clear that that requires investment. When it comes to hub and spoke, you give your prescriptions to a corporate hub to dispense for you, but a lot of independents—particularly our members—are the ones who are very close to their patients. Prescriptions are some of their bread and butter. Imagine taking that prescription level, which is their bread and butter at the moment, and giving it to a massive hub. Remember that 90% of independent pharmacies' activities are NHS-related. If you give that to a hub, all of the pharmacies that are dependent on that in the rural areas and in the heart of the community will not be able to survive.

At the moment, you have a network of community pharmacies that, together, bring the prices down because there is competition. If you have just a few hubs that can do that, would there be any competition or would the NHS end up paying more because there is less competition in the market? From our perspective, we have to be very careful about how we view hub and spoke. We need to be very mindful of the fact that it is an expensive matter. Not everybody can operate it. It could also potentially damage the livelihood of pharmacies and the communities in which they are situated.

Q22 **Chris Green:** There is a question over, broadly, two types of models. One is that people come to the pharmacist, the pharmacist gets the prescription which comes back to the pharmacist and then gets given to the customer; or it gets posted or sent directly to the customer.

Malcolm Harrison: That is not hub and spoke; that is distance-selling pharmacy. They are very different things. Hub and spoke is very much predicated on the patient going to the spoke pharmacy. It is just that the dispensing is done elsewhere. The actual supply is made by—

Q23 **Chris Green:** My point was that from the dispensing hub it can either come back to the pharmacist or be sent.

Malcolm Harrison: No, that is a very different model. If you are a different legal entity, as a spoke you would want to contract that the medicines come back to you and your patients access them from you. I am not sure that the risk there is significant. Obviously, there is another model of pharmacy which is distance-selling pharmacy where, yes, there is an ability to automate, centralise and then supply at national level. That presents other challenges around the contracts from the NHS, but for hub and spoke I am not sure that is a particular risk.

Q24 **Chris Green:** Is there anything else, Dr Hannbeck?

Dr Hannbeck: It is very difficult to expect that many independent community pharmacists will hand over their patient data and prescriptions to a hub to dispense. We must remember that the reason why we have our community pharmacists is accessibility and the patient relationship. Hub and spoke is not for everyone. It will create an unfair surrounding for the sector, definitely.

Q25 **Chris Green:** Thank you. Mr Badenhorst?

Jay Badenhorst: We have a hub and spoke operation in the organisation I work for, and we do it for 10 pharmacies from Newcastle, stretching down the A19 all the way to York. We are actually thinking of stopping it because there are no efficiencies in it. What we managed to create initially, when there was a little bit more money in the system, was capacity in some of the pharmacies, but that has been eaten up very quickly by delivering covid vaccination clinics and that sort of thing.

The complications that it has brought to us have been numerous—for example, the shortages of medicines. Quite often, it is predicated by a quota. The pharmacy as a spoke may be able to order some, but that is not allocated to the hub, so the hub cannot order the quota medication in sufficient quantities to serve the spoke. There are controlled drugs. How do you deal with those? There are fridge lines. You cannot transfer that all the way from Gateshead down to York appropriately. Unfortunately, even within one organisation there is so much that we could not make work, notwithstanding all our costs, that we are now thinking of saying, “Do you know what, there is so little in this that we are actually just going to split it back down to the spokes and deliver the services from there?”

To scale that model up to inter-company, you start thinking about all of the legal stuff. Am I responsible as a superintendent, or will the hub superintendent pharmacist be responsible if something goes wrong? Unfortunately, that has not been tested in the courts yet. There are so many things. It may play a part in the global health system somewhere, but it is definitely not a silver bullet that we are all going to rely on to solve all the issues.

Q26 **Chris Green:** I appreciate that. I have one quick point. National Government have a big role and a big responsibility, but in terms of the

integrated care system and recognition at the integrated care board level, how do you feel it works at the moment?

Jay Badenhorst: I can only talk about North East and North Cumbria. We have a very good relationship with the integrated board in the system in North East and North Cumbria, but I think we recognise that we are at the start of our journey to commission services locally. However, saying that, for some of the national services coming out—for example, the UTI service as part of the £6.5 million that has been announced—we have been doing that for a number of months already in North East and North Cumbria, where we operate some of our pharmacies and I am on the LPC.

In the first few months, up to now, we have delivered something like 15,000 consultations. That is a really good example of how local commissioning, driven by an engaged pharmacy team, together with an ICB team, meets local population health needs, and does it very well. Although we are still at the starting point of our journey, I am quite encouraged by the way it could be. Of course, we need a national framework and everything else, but there is definitely a role for local commissioning, and we should expand that if there is the opportunity.

Q27 **Chris Green:** Dr Hannbeck?

Dr Hannbeck: With regards to local commissioning, it is good to see that ICBs and ICSs have a role for multidisciplinary teams, as it was very much focused on one profession, so long as that continues. It is important, when I talk about the cultural hierarchy, to understand that it impacts on ICBs as well. We must get away from the same way of thinking that the NHS has always had, focusing on the things that it has always done, and instead open up the mindset and overcome the cultural barriers to see what we can do.

For example, one project that we are involved with is to work with cardiologists and doctors to look at how we manage cardiovascular disease better locally and how we bring down the number of diabetic patients and support them better. The multidisciplinary team is something that we really strive to move forward with, but there has to be the right mindset, culture and willingness within the ICBs for that to happen. We can say what we want, but as long as that culture is not there and no one is listening it is going to be a barrier.

Q28 **Chris Green:** Mr Harrison?

Malcolm Harrison: I am interested or intrigued by the juxtaposition of your questions. Your first question was about efficiencies and your second question was about local commissioning. I think that efficiency comes from standardisation and from scale. While there definitely is a need for local decisions to be made in the health system in this country, I am not sure that designing and commissioning things locally across 42 different ICBs is the best way of using taxpayers' money to meet healthcare needs. If there is to be local commissioning—there obviously is—we

would like to see the standard approach to it. If you are addressing emergency hormonal contraception, blood pressure or diabetes, the way in which you treat the individual is going to be the same, whether it is in Lyme Regis or Liverpool.

We need a standard approach to doing things, and then a decision can be made locally on whether or not they are commissioned. What we do not need are 40-odd different ways of doing things. It is not just the ICBs. We have hospitals that want to generate their own IT systems, their own shared care records and so on. If you are trying to deliver something at national level and you have to work with so many different designs, IT systems and methods, it just increases risk, if I am honest. I am sure the superintendent would say that having to try to deliver something in a number of different ways increases risk. Local commissioning is definitely needed within the health system, but only if it can be done to a standard specification.

Chair: Thank you. Finally, I will bring in Dr Caroline Johnson.

Q29 **Dr Johnson:** Thank you, Chair. There are a couple of things I want to pick up on. You talked at the beginning about the squeeze on community pharmacy funding and drugs. I want to be clear on that. My understanding is that when it comes to NHS prescriptions, you receive an amount of money on the drug tariff for the individual drug that you have prescribed, and then you get an additional fee for actually dispensing, handing out the drug. Which of those is being reduced? When you talk about the drug tariff, how often is that set, and how often would you like it to be set? You talked about there being a lag between the fluctuation in the price of the product and the changes in price of the tariff.

Malcolm Harrison: Both—is the answer to which is being squeezed. The fee that we receive for dispensing—the single activity fee—has not changed since 2016. While we have a continual increase in the volume of activity that is expected of us, that money is having to go further and is being spread further and further.

Q30 **Dr Johnson:** Isn't it a fee per prescription dispensed?

Malcolm Harrison: It is, but it is a closed sum. There is £1.3 billion. If you do more and more items, you get paid less and less for each because the fee is capped. It is not a fee that is set irrespective of the volume of work you do. The sector as a whole is capped, so the more items we do, the more the NHS prescribes, and the more medicines we have to source, the less we get paid for each one. That is part of the problem. It does not recognise the inflationary cost pressures of running a business either, plus some of the challenges we have found with the workforce doubling in price recently. That is a challenge.

The other challenge is the available margin. Yes, community pharmacies are incentivised to buy well because there is £800 million a year of available margin for them, but again the challenge with that is that more and more medicines are put into the pot that we have to source. The

volume is going up and the cost of medicines is going up. That margin is getting squeezed and squeezed to a point now where many pharmacies have to dispense at a loss. It is unsustainable.

Q31 **Dr Johnson:** You talked about the squeeze on generic medicines. I want to ask you about branded generic medicines. At the moment there is, as I understand it, a voluntary pharmacy scheme where the companies that sell branded generics pay a little bit into a pot to try to limit the cost of branded generic medicines overall. They described the global market that Dr Hannbeck was describing earlier and said that they were not going to sell into that market; they were going to sell into a market elsewhere in Europe or overseas because of the squeeze in costs and, as a result, we see shortages in pharmacies. Do you think that is an accurate reflection?

Malcolm Harrison: I am not sure that is a unique reflection for branded generics. Branded generics is an interesting concept; a drug comes off patent and a generic manufacturer puts a brand to it and then sells it through a different mechanism. It is one of the complexities that Leyla mentioned earlier and probably needs reviewing. What you describe, and what they have reported to you, is very real.

As a drug manufacturer operating in a global market, where are you going to sell your medicines? We have seen some examples in recent history, with the shortages of HRT and so on, where there is product globally, but it is not coming to these shores. This Government and the NHS need to ask themselves why we are struggling to get medicines for our patients here when they are available elsewhere. Is it because they can be sold elsewhere at a higher cost? I am not suggesting that we want to be paying top market prices, but we need a market that businesses realise they can work in.

Q32 **Dr Johnson:** Thank you. Dr Hannbeck?

Dr Hannbeck: I want to reiterate the point that the medicine shortage problem is a real problem. The whole system needs to be reviewed in terms of how we source medicines and what processes and schemes are in place with manufacturers.

The problem we have is that over the past few years, we are seeing medicines, all of a sudden, not being available at all. They are very common medicines—for example, antibiotics. We see at first hand the stress that it causes our patients with regard to ADHD or HRT medicines. We can see at first hand the impact it has on patients. We constantly find ourselves in the loop that medicines come on the market and then, all of a sudden, as soon as the demand goes up a little bit, they are no longer available. That indicates that something in the system is not right and we need to tackle that. By reviewing the whole system, it is something that we can achieve.

I don’t feel that enough is being done within the Department to look at every aspect of what we can do better to make medicine availability

better in the UK. There need to be better communications with everyone across the medicine supply chain, to make sure that we tackle all the challenges that everyone has, being aware of the fact that there are some global things outside our control, but that there are many things within our control that we need to manage by having that communication going on.

Q33 **Dr Johnson:** I am interested in the drugs that become unavailable. As you said, it is very stressful for patients. You can have a drug that is new and perhaps becomes unavailable because supply has outstripped the capacity to produce it in the initial stages. You can have a generic drug that a lot of people take, say Ventolin, which comes off patent and becomes salbutamol and millions of people use it, so there is a market in producing that sort of drug. With modern drugs—biologics and modern preparations of old drugs, perhaps, with slow-release preparations of budesonide and suchlike—they are specific and not necessarily used by large numbers of people. Even when they come off patent, there is not necessarily a huge market for generics to produce them. Do you find that you see more shortage in those sorts of drugs and branded drugs, or do you see more shortage in generic drugs, simple things like amoxicillin? What sort of drugs do you see shortages of, Jay?

Jay Badenhorst: Maybe I can answer that from living and breathing it every day. I wake up and have pharmacies ringing me saying, "I can't get hold of atorvastatin," for example, which is a very common drug. Of course, we have to buy the medicine in good faith that a concession will potentially be granted. For example, I may be paying £5 for it at this moment in time, but the drug tariff is set at £1.20. It is then up to the negotiating committee from CPE to negotiate a concessionary price for that medicine, which I have already bought for more than I will be paid.

Of course, what happens later on is that if a concession price is announced and the medicine gets reimbursed at an appropriate price, because of the flat funding in three months' time or a year's time, as Malcolm explained earlier, there is an announcement that, "Oh, you've now made too much money on that," which we have not because it is a concessionary price based on how much we paid for it, and they claw money back from the pharmacies again. First, you start buying in good faith that you will be appropriately remunerated for the medicine that you now have to buy, which is still higher than the drug tariff price and, secondly, you get clawed back for the medicine you have already paid for because of the flat funding. Overall, you make a loss.

Specifically on your question, we currently get paid £1.24 per item to dispense. That is very little and has been the result of the changes to how we were paid before. If you roll back to before the 2016 letter, there was a much more complicated system of having a dispensing fee and a professional fee and everything else. It was rolled into one fee. The volume has slowly grown. I think when we started it was roughly about

£1.67 when it was initially set. Over the years, as the volume has grown, that fee has dropped and dropped to about £1.20 now.

The drug tariff gets renewed every quarter. Unfortunately, I don't think that is appropriate. We have real-time information available with electronic prescriptions these days. If I press a button and it goes to the BSA—the Business Services Authority—they know exactly what I dispensed during the month. To make things worse, if I miss the 5th of the month, I do not get paid at all for that month. I need to submit my prescription figures. They go to the BSA. They look at them and give me a sum of money based on my dispensing. Later in the month, I get a little bit more of what I did three months ago. That fluctuation in cash flow is absolutely crippling. We cannot plan for that.

We do not even know what is going to be announced as a concessionary price. Throughout the whole month, we have to buy in good faith that someone somewhere will decide, "We are going to remunerate you for the medicines, at least at the price you've paid for them." But we do not know that sometimes until into the following month for the previous month. If you also missed the 5th of that month for submitting your prescriptions, despite the fact that you have already bought all of those medicines at a loss, you do not get granted concessionary prices on those medicines. The whole system is broken. It needs to change.

Q34 **Dr Johnson:** Do you think drug companies bear any responsibility for this? They have a market that wants to buy in the UK. They could increase international production and supply more. Do you think the shortages are a mechanism for inflating their prices, and thus their profits?

Malcolm Harrison: No. The global market is very complex. Where we see shortages, quite often it is because of unexpected things on the manufacturing side of things. An earthquake in central Asia can disrupt the production of a core ingredient of a medicine, which then has an impact across the supply chain. There is not enough meat on the bone to create a just-in-case model. It is a just-in-time model. Manufacturers do not have a buffer to be able to meet spikes in demand. If public awareness suddenly rises for a certain medicine, and demand goes up, manufacturing has not anticipated it. It is a very fragile market.

There is a risk that we could end up playing whack-a-mole, trying to hit each individual spike as it arises. For me, it is symptomatic of an underlying underfunding problem. When you have a very fragile market and there isn't enough room for any kind of error, or any kind of ability to absorb any sort of pressure, that is when it continually falls over. You can either run around with a box of sticking plasters and try to stick one on each problem as it arises, or we need to fundamentally review how we source medicines in this country, to ensure that when we are operating in a global market, we are able to bring the medicines to these shores.

Dr Johnson: May I have one final question?

Chair: I am going to Paulette because we are tight on time. We have another panel after this.

Q35 **Mrs Hamilton:** Thank you. Mine is one quick question. When all this was being negotiated, especially during and just after covid, I kept asking the question from the position I sat in at the time: "Are pharmacies sure that they want to take on all this extra work?" We saw the issues that happened with GPs and I wondered if you would end up in the place that you are now in. Everybody kept saying, "This is the way forward," and it would work.

You have made some really valuable arguments today. I don't care who answers the question. Some of this was predicted as far back as two or three years ago. What was done by the different organisations was to say to the Government, "Look, these are the challenges. If we take this on, and we support and help what you are trying to do, what are you going to do for us?" What messages were being sent to Government to predict some of what is now happening?

Malcolm Harrison: We have been saying for many years that the funding isn't there. Businesses feel that they have to do more and more activity to earn money to be able to resource what they—

Q36 **Mrs Hamilton:** To cut it short, do you feel that you did not have a choice but to go into the new ways of working?

Malcolm Harrison: Pharmacies have a contract with the NHS to provide NHS services. There are essential services within that which we have to provide as part of that contractual service. We have a negotiating body, CPE, who work as hard as they can to negotiate the best price that we can get for doing those, but ultimately, as I mentioned earlier, there is only one buyer in this country and that is the NHS. There is very little room for us to dictate any kind of price in these things. We are asked to deliver certain things in order to be able to maintain a contract to supply medicines for the NHS—

Q37 **Mrs Hamilton:** Just to cut the subject, because the Chair is going to have a go at me, you felt—a yes or no answer—that you had no choice and you were not being listened to, even though you had seen these problems and you knew what would happen. You were saying it, but you were not being heard by Government or the powers that be.

Jay Badenhorst: Absolutely.

Dr Hannbeck: That's right.

Jay Badenhorst: I think we have gone a step further. The National Pharmacy Association has commissioned an EY report, which has very good evidence and has been presented to the Department. We have recently had another report by University College London and by the London School of Economics where it was predicted. Even the expert panel rated the overall review as "Needs improvement", so it is inadequate. Not only have we provided evidence from the representative

bodies, but even the expert panel has finally said, "Actually, it is inadequate and needs improvement."

Mrs Hamilton: Thank you, Chair, for allowing me to ask that.

Chair: Thank you, Malcolm Harrison, Dr Leyla Hannbeck and Jay Badenhorst. We really appreciate it.

Examination of witnesses

Witnesses: James Davies and Dr Stretch.

Q38 **Chair:** We now switch to looking at primary care pharmacy and hospital pharmacy. I welcome Dr Graham Stretch, the president of the Primary Care Pharmacy Association and chief pharmacist at Argyle Health Group, and Dr James Davies, director for England at the Royal Pharmaceutical Society.

I will open with a general question to both of you, starting with Dr Stretch. What are the key challenges and opportunities that you see in primary care? We will have a look at pharmacy after that.

Dr Stretch: Primary care in its broadest sense includes my colleagues working in community. Right now, it feels like we run a team in primary care networks but we have one of our key players on the bench, not on the field. We need to bring him on to the field. Let me say that from the start.

In primary care, we just soak demand. There is no finite quantity of demand. There were 340 million appointments in general practice in the year to September. There is an enormous amount of activity, in a world where we recognise that more than 1,000 GP practices have closed in the last 10 years and there has been an 8% fall in the number of GPs, despite everyone's best efforts. We can talk about capacity where pharmacists and the other ARRS staff come in, but it is really important also to focus on the quality aspects—the expertise and safety that we bring in the system. Where we get those things wrong, the knock-on effects in other sectors, and in the hospital sector, will apply.

The challenge, of course, is to balance within the system and our available workforce how we deliver services and where we deliver them from. We all agree that that needs to be done in the most integrated way possible. That is really where I see the challenge. How do we integrate our available workforce appropriately? How do we spend money in the best possible way to allow our patients to access the care they need in a timely way, as cost-effectively and as close to home as possible?

Q39 **Chair:** James Davies.

James Davies: I am from the Royal Pharmaceutical Society. As an organisation, we represent pharmacists in all sectors of practice, but my focus here is very much on hospital practice. Some of the challenges that we see are ones you have already heard about this morning, related to

workforce, medicine shortages and the constrained funding envelopes that exist.

Building to some extent on Graham's point, pharmacists in hospital do not sit in isolation. They are part of the teams that work in hospitals, experiencing some of the same challenges that lots of the other healthcare professionals who have been before you experience. A lot of that is related to increased demand, with some of the backlogs as a result of waiting lists and the challenges they have in treating various different patients who are coming through.

There are lots of opportunities in how we can expand and use the skills of pharmacists further, not just in hospitals but across the whole plethora of healthcare. One of those big opportunities is in prescribing. From 2026 onwards, all newly qualified pharmacists will be prescribers. There are lots of opportunities to use those prescribing skills to better effect. There are lots of opportunities around skill mix and making the best use of not just pharmacists, but the entire pharmacy team, particularly pharmacy technicians. There is another opportunity around clinical trials and the roles that pharmacists and pharmacy teams can play in our life science sector.

Chair: Thank you ever so much. I am going to hand straight over to James Morris.

Q40 **James Morris:** I want to talk about some of the workforce issues. I think, Dr Stretch, you heard the previous exchanges around the additional roles reimbursement scheme. The argument is that there has been the law of unintended consequences in the impact of that scheme; essentially, filtering people out of the community pharmacy sector into primary care. What do you make of that?

Dr Stretch: It is important to recognise that the funding for ARRS comes from negotiations between the BMA GPC and the Department. That is core funding that was general practice funding. In the NHS long-term plan in 2019, £890 million annually by 2023—by this year—was promised to general practice as part of the inception of primary care networks to fund these additional roles. There are very many professions, not just pharmacists, within that. That is the context. That was done for the reasons we are aware of, around the pressures on general practice.

The actual numbers are very interesting. ARRS supports 4,689 pharmacists, of which, in July 2019 to September 2023, 3,047 have come from the community sector. That is a significant number and I am not pretending otherwise. In the same period, the GPhC register has grown by 7,308, more than double the number of pharmacists moving from community into PCN. That oversimplifies things, because we have portfolio roles.

I think that is a good model. I was a clinical director in a primary care network. We tried to establish where we would commission community

pharmacy to be the employer and deliver services for PCNs from the community pharmacies, but there are lots of constraints and rules and regulations around how we use that ARRS money.

Q41 **James Morris:** You accept that there has been a negative impact on community pharmacy.

Dr Stretch: I do.

Q42 **James Morris:** Would you be in favour of opening up the scheme or making some modifications along the lines that you were just describing? What modifications to the scheme would you like to see?

Dr Stretch: Primary care networks should be exactly that; they should be networks of the whole of primary care. It is not necessarily around where this ARRS member of staff sits. It is around delivering primary care. We need to ensure that community pharmacy is part of that network, but we need to be careful that with these moneys we are not, as we heard, robbing Peter to pay Paul. These were moneys that were part of the general practice contract negotiations. We need more money in the system. That is clear. You have heard that from my colleagues, who have articulated it very well. I think that the best way of delivering services is as close to the patient as possible and I recognise community pharmacies as being a place to do that. The general practice work that ARRS delivers can very often be done from a community pharmacy. I will accept that.

Q43 **James Morris:** Notwithstanding the funding discussion, which I know is not trivial, you would like to see further integration.

Dr Stretch: Yes. That is a good word for it. My view is that the quality aspects—the expertise around review of medicines, around safety and the use of medicines—can be done on behalf of general practice and PCNs within a general practice. Often, they can be done remotely. They can certainly be done within a community pharmacy.

The quality job around medication review is the thing that reduces hospital admissions and medication-related harms and, therefore, improves patients' quality of life and reduces cost in the system. It seems to me that if I am a patient, as long as the job is being done, I don't actually mind whether I am in a community pharmacy or a general practice. The important thing is that the jobs need to be done. The venue for that work is less important. We have put a lot of effort into trying to work in an integrated way. Yes, I would be entirely content with the ARRS moneys being used to deliver those services from wherever is best placed to deliver them.

Q44 **James Morris:** Okay. Dr Davies, do you have any reflections on the workforce challenges more broadly?

James Davies: Yes. In hospital practice, we have also experienced those shortages. That has led to some changes in service delivery to manage the impact.

One of the things that I would mention, as an organisation that also represents pharmacy students who are coming through and looking for opportunities, is that there was a clear commitment in the long-term workforce plan to grow the number of places for pharmacists coming through, by between 30% and 55% for education places. This is one of the examples where pharmacy sits in a slightly different place from other professions. For example, in nursing, midwifery and other allied health professions and in medicine and dentistry, they have access to the learning support fund. In those professions, that gives students an opportunity to have funding for their accommodation, their travel and their ability to go to different sites when they go out on clinical placements and take on more clinical roles.

At the moment, we are seeing shortages in particular areas of the country. It is always more challenging in more rural areas. One of the ways to address that is to get students to go and do placements in those areas so that they can understand what practice is like there. Then they might go on to practise there later. At the moment, pharmacy is excluded as a healthcare profession from access to that fund.

Q45 **James Morris:** On that, are you saying that the commitment in the long-term workforce plan is not deliverable?

James Davies: I am saying that the commitment to grow the places is there. Whether there is enough support for those places to be where we actually need them is different.

Chair: We will be looking at workforce in a future session. I am sure that we will delve in deeper there. I call Paulette Hamilton now.

Q46 **Mrs Hamilton:** Good morning, both. Can I start with Dr Stretch, please? I am really passionate about general practice, because I came from primary care. I am sorry; I am rethinking my question—I have had a terrible morning. I have heard a lot of negatives since I walked into this room. Could you give me some positives on the idea and thinking around pharmacy being part of primary care and why it is so beneficial that it is in that particular system?

Dr Stretch: This is the quality thing. This is the expertise and safety that we can deliver. If we look at the numbers now, we have around 7,000 pharmacists working in English general practice. We are delivering 2.8 million structured medication reviews, a half-hour appointment when we sit with patients with frailty—patients in care homes and patients on 10 or more medicines—who are particularly susceptible to harms that might lead to unplanned hospital admissions. In the year to September 2023, 2.8 million people had those appointments.

At the same time, to look at individual examples, we have pharmacies that are working to reduce opioid overuse. That has been reduced by 80% in Barrow in Cumbria, for example, and by 65% on the Norfolk coast, which I visited recently. They are making huge differences to individual patients by concentrating on and recognising the medicines that are most likely to cause harms. In my own service in west London, we have 1,200 patients in nursing homes. We have reduced unplanned hospital admissions by 20%. We have reduced the number of patients having to access end-of-life care in hospitals by 40%. We have reduced medications such as the antipsychotics that are used to manage behaviour—often wrongly—in dementia patients, leading to stroke and other complications, by more than 60%, and overuse of broad spectrum antibiotics by 80%. Those are single examples that I use just to illustrate the kind of work that we are doing.

To go back to the 340 million appointments in general practice in the year to September, *The Daily Telegraph* recently ran a piece that said that fewer than half of those are with your family doctor. That is a very emotive way of putting it, but if patients who may have musculoskeletal problems are seeing a physio, those with mental health problems are seeing a mental health practitioner or, of course, those with medication-related problems are seeing a pharmacist, we have absolutely moved general practice from being about doctors to being about a team where, probably, the doctor is the captain and the conductor, but they direct patients towards the practitioner and profession that is most able to have the expertise to deal with the particular issue of concern to them. I celebrate the fact that, of the half of the appointments that were done by non-family doctors, about half were with nurses and another quarter—40 million or so—were done by pharmacists and pharmacy technicians. That is the capacity that we have added to the system.

Think about your mailbox and patients saying, "I can't get an appointment." The ARRS scheme has funded an enormous amount of capacity. It is not just about bean counting and ticking boxes. What it has done is allow patients to see an appropriate practitioner. Obviously, I will talk about pharmacists.

Q47 **Mrs Hamilton:** That is the point at which to stop. I am going to ask Dr Davies absolutely the same question, but relating to hospital pharmacists. The Chair is going to shut me up, so can you answer in not too many words? If you were looking at the vision, what would you like to see for hospital pharmacy going forward?

James Davies: It is building on the same points as Graham. Pharmacists are key to understanding medicines. It is about quality and safety. Where we have pharmacists on the ward, as part of a multidisciplinary team, looking at the supply of medications, we know that patients get better medicines, they get safer medicines and they get them at the right time, which helps them to move through the hospital faster. We would like to

see pharmacists on every ward, and we would like to see a wider team to enable that to happen.

Q48 **Mrs Hamilton:** This is my very last question to both of you. What would you like us to say to the Government, or future Governments coming in, so that you can get to the point where you believe this service needs to be? I will start with you, Graham.

Dr Stretch: Invest in people. Invest in workforce and in training so that we can bring through the skills that we and patients need so that their needs will be met appropriately. Sustain joint training posts across the sectors, sustain portfolio working and facilitate commissioned healthcare responsive to the needs of our local communities.

Q49 **Mrs Hamilton:** Brilliant. James Davies?

James Davies: Investing in the workforce and the people is essential. That means investing not just in pharmacists but in pharmacy technicians and the wider pharmacy team, to make sure that they can all contribute to using people's skills in the best possible way.

The other thing is investment in facilities. Our teams are at the frontline, and patient care takes absolute priority. Where we are in very constrained funding envelopes in different trusts, the focus is very much on how to treat the next patient. Therefore, the long-term investment that needs to happen in some of the infrastructure, some of the pharmacy departments and some of the facilities for manufacturing medicines has not been at the level that it needs to be. There has to be investment in the facilities, as well as the investment in the workforce.

Mrs Hamilton: Thank you both for that.

Chair: We have seen from our future cancer inquiry the pace at which pharma is moving forward and the opportunities that that will present. I will bring in Chris Green.

Q50 **Chris Green:** Dr Davies, you mentioned people and facilities. Can you briefly describe some of the automation and technological solutions that we can see in hospital pharmacy across the NHS?

James Davies: There is a lot of innovation happening. It is fair to say that innovation is happening in individual trusts. There is no single panacea that goes across all trusts in the same way. In those at the forefront, we see full electronic patient records and full electronic prescribing systems so that the patient has a digital journey all the way through their experience in the hospital, which means that we have a really good idea of where the medication is going and how the medicines are being administered and used. That helps from a safety aspect and a quality aspect. It also helps from a cost aspect. At the other end of the spectrum, some hospital pharmacies, or hospital teams in general, are still very much working on paper systems. They are in a place where the innovation to move forward to use more digital opportunity has not

happened yet. I know that this Committee is well versed in digital maturity across the NHS, which is stifling some of that.

One of the other areas of real innovation that is happening is in clinical trials, which I touched on. Often some of the unsung heroes in hospital pharmacy are those who are working in technical services. They are often buried down in the basement somewhere, where you won't see them. That is where IV medications are being manufactured and biological medications are getting pulled together. We are also seeing parental nutrition and other things happening in that area, as well as the innovative, forward-thinking meds that we might want to use for gene therapy or other areas like that. Those pharmacy services need to continue to have the investment and support to deliver those trials and medications to patients. We would like further investment to happen there.

Q51 **Chris Green:** There is a contrast between some areas that are looking into gene therapy and other areas that cannot get out of a paperwork-type system. What are the barriers to raising standards right across the NHS? What is stopping certain hospitals or places elsewhere improving?

James Davies: These are probably reflections not just on the hospital pharmacy team but on the overall trust and the set-up in general. Often there is a lot of leadership that needs to make that happen. Where we have seen innovations move forward, particularly in hospital teams, we have very strong chief pharmacists, a chief exec and a team in the trust that are supportive of the pharmacy team and the investment to move that forward.

In trusts or areas where they struggle more, it is often because there has been quite a change in leadership and they are struggling in lots of areas of their practice, not just the pharmacy practice, but workforce across all the different teams. As to some of the ways to deal with that, yes, funding helps, but it is also about getting the right people in the right place to make those innovations happen. That is particularly true of digital innovations, For example, if you bring in an electronic prescribing system to help with the supply of medications, you need all the doctors, nurses and teams that are involved to understand that system and to have access to the right IT and the right equipment. It takes a whole system-wide, multi-team approach to make it happen.

Q52 **Chris Green:** I appreciate the point about leadership and how that can drive improvements right across the system. Do you think that the integrated care systems and the integrated care boards are taking the right actions in areas that need better development?

James Davies: We certainly see variety. Within a single ICB, we may see different trusts at different levels of maturity and with different ways of moving forward. In some ICBs, pharmacists are sitting on the board and are a key part of the team. In others, the pharmacists are not quite in that leadership position. We would like to see a chief pharmacist on the

board in every ICB because medicines are key all the way through the system, be that in primary care, in secondary care or even in tertiary centres. We want to make sure that pharmacists are there, are involved and have oversight wherever they work in the system.

Q53 **Dr Johnson:** Dr Davies, you have talked about the expanded use of skills and the new roles that pharmacists could take on. You have also talked about the view that there do not appear to be enough pharmacists to do the work that they are doing at the moment, which contradicts that slightly.

I want to ask about a key service that pharmacists provide in hospitals—the dispensing of the TTO, or the to-take-out medication. When a patient is ready to go home, they get their TTOs prescribed by the doctor. Then they wait, and wait and wait, for those drugs to come up from pharmacy. It is not at all uncommon for people to wait most of the day for those drugs. If it is done on the morning ward round, it is not uncommon to wait until the afternoon. There are examples of patients staying an extra night in hospital, contributing to difficulties in A&E and bed shortages, because the TTOs are not ready. There are patients who have been discharged from hospital without TTOs, with TTOs following them in a very expensive taxi to their home, because the TTOs are not ready.

What are the challenges? I should say at this point that I am a hospital doctor. When I prescribe a TTO, or when one of the junior doctors prescribes a TTO, it goes into a black hole and re-emerges as a medicine many hours later. What happens in that space? What is the challenge it creates that makes it take so long?

James Davies: When I was a hospital pharmacist, most of my life was dedicated to getting TTOs sorted and out of pharmacies. It is fair to say that the movement of patients from the point at which they are registered discharged to actually leaving a hospital involves a whole team of people. It is not just a pharmacy team that makes that happen. It is also the relationship with doctors and with other areas of practice, to make sure that the prescribing happens, that it is written in an effective way and that those medications are available to support the patient leaving.

There are lots of areas that can be supported and helped to move forward. There is some good evidence for that. One of those is around better use of pharmacy technicians and using that workforce to support pharmacists to get things ready before the anticipated discharge, working closely with a team to make sure that as many medications are ready as possible.

Another area is where we see prescribing pharmacists. I touched on the fact that from 2026 pharmacists will be able to prescribe on registration, but around a quarter of the pharmacy register are already prescribers. I was at one of the London hospitals last week. The pharmacist was working on an orthopaedic ward, a high-volume ward, with TTOs coming

through regularly and patients moving through quickly. The pharmacist was writing the TTOs, getting them ready and then having to find a doctor to sign off the final prescription, to allow the patient to be discharged. That pharmacist is going through a prescribing course. In a couple of months' time, they will be in a situation where they can prescribe, get the medications ready and help to make it happen. They will not be relying on other people in the team to make that happen. They will be able to help to speed it through the process.

Q54 **Dr Johnson:** That is great. You can anticipate it. Our junior doctors are advised to anticipate discharging and to prescribe TTOs. You say that the pharmacists can prescribe them, but what I asked you is this: when the prescription has been written by the junior doctor and has disappeared into the black hole of pharmacy, why does it sometimes take hours? If I go into a pharmacy like the chaps we spoke to in the first session—a pharmacy in Asda, the local supermarket, or a local pharmacy at the end of the street, such as Boots or a chemist—and give them a prescription, they will come back 10 or 15 minutes later and have my prescription ready. What I am trying to understand is this. When the prescription has been written by the doctor and it is six hours from that point until the drugs come back, what is the resourcing? What is the issue that takes so long? We have had to create whole lounges in hospitals for patients to sit around and wait. We have discharge lounges where, essentially, people sit and wait for many hours. Poorly people, who are only just well enough to go home, sit for hours waiting. What is going on?

James Davies: First, I challenge that discharge lounges are just for TTO medication. We know that there are a lot of other reasons why patients are not discharged from hospital. It is not just around the access to TTOs.

What happens is that the prescription gets written and goes through to the pharmacy team. The pharmacy team check it to make sure that it is safe, has been prescribed appropriately and is the right medication for discharge. Often, therefore, they have to make changes and make sure that the medication that has been prescribed and written is appropriate and safe. That process is there to make it better for patients, to stop readmission and to improve the overall quality of the system. That takes some time.

The next step is to prepare those medications, to make sure that we have them and that we have the right medications available for each patient. There isn't just one prescription coming in; we have TTOs coming in from all over the hospital, across lots of different wards and for lots of different patients. There is a capacity within there to be able to get those done as quickly as possible. The medications then have to make it from the pharmacy to wherever the patient is. That relies on portering services and different teams and areas across the hospital to get them back to the patient, ready for eventual discharge.

Q55 **Dr Johnson:** You are saying that the issue is capacity in pharmacy and capacity in portering services.

James Davies: And capacity in clinical checking. If the TTOs that came through were always accurate and correct, that would also speed up the process.

Q56 **Dr Johnson:** I cannot recall being asked to correct a TTO. What percentage of TTOs require correcting?

James Davies: It varies by trust, location and ward type. I don't have exact information for you, but I can certainly provide some. I can write to you afterwards with some of the research that has already been carried out in that area.

Q57 **Dr Johnson:** Thank you. It is a key frustration and means that people wait around for a long period and creates backlog in A&E.

The other issue I want to ask about is electronic prescribing. Many GPs have electronic prescribing. I recall having a migraine one day and my GP prescribing some meds. I thought that I would have to pick them up when I got back to Lincolnshire, but in fact they were able to be dispensed at a Westminster pharmacy, through the electronic prescribing scheme. It is obviously great for patients to be able to get that where they want to be.

That is particularly true of hospital practice. When I write a prescription in a hospital, I have to do it on a white form, not a green one, and it can be dispensed only in the hospital pharmacy. That means, for example, that if a little baby that is jaundiced comes to clinic, they do all the tests and it turns out that they have a urine infection, and I want to prescribe that baby an antibiotic, the parents have to take their tiny baby perhaps 30 or 40 miles to the hospital to collect a hospital prescription. Wouldn't it be much better if hospitals had access to electronic prescribing so that they could send those prescriptions out to pharmacies in more distant locations, closer to the patient and better for their care?

James Davies: Yes, is the simple answer to that.

Q58 **Dr Johnson:** Would that help with your capacity issues on TTOs as well?

James Davies: In some areas, it would. In some out-patient clinics, it would support that. At the moment, there isn't the integration that we would like between the electronic prescribing systems that are happening in primary care and those that are happening in hospital practice. Talking to the innovations, there is a lot of opportunity for transfer of prescriptions electronically between secondary and primary care settings.

Chair: Thank you, colleagues and thank you ever so much, Dr James Davies and Dr Graham Stretch. That concludes the opening session of the pharmacy inquiry. It will continue with the next session of this inquiry in the new year, but we will be back next week.