Health and Social Care Committee

Oral evidence: Pharmacy, HC 140

Tuesday 26 March 2024

Ordered by the House of Commons to be published on 26 March 2024.

Watch the meeting

Members present: Steve Brine (Chair); Mrs Paulette Hamilton; Rachael Maskell; James Morris.

Questions 178 - 226

Witnesses

I: The right hon. Dame Andrea Leadsom MP, Parliamentary Under-Secretary (Minister for Public Health, Start for Life and Primary Care); Dr Amanda Doyle OBE, National Director for Primary Care and Community Services, NHS England; and David Webb, Chief Pharmaceutical Officer, NHS England.

Written evidence from witnesses:

- [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Andrea Leadsom, Dr Doyle and David Webb.

Chair: Good morning. This is the Health and Social Care Select Committee for the second day in a row. Yesterday we had the permanent secretary and the Secretary of State. Today we are concluding our inquiry on pharmacy. We are looking at community pharmacy and hospital pharmacy. We are looking at the sector and, as is tradition, we conclude this inquiry by having the Minister. Welcome again, for the second week in a row, to the right hon. Dame Andrea Leadsom MP, who is the parliamentary Under- Secretary for Public Health, Start for Life and Primary Care, otherwise known as the Pharmacy Minister, which is why you are here today.

Dr Amanda Doyle is also back for the second week in a row—can't get enough of us. She is national director for primary care and community services at NHS England. David Webb is the CPO, the chief pharmaceutical officer, at NHS England. Thank you very much for joining us.

I place on the record that I am one of Andrea's predecessors as the Pharmacy Minister. It is one of the best jobs in government and I loved doing it. Does anybody else have anything they wish to place on the record?

James Morris: I was Pharmacy Minister for a short period.

Q178 **Chair:** Andrea, let us start with Pharmacy First: "The pharmacist will see you now." The Company Chemists' Association sent us their Pharmacy First for the first month. Nearly 50,000 Pharmacy First consultations were provided in the first month by their members. There were two and a half times more consultations in more deprived areas. Nearly a third of all consultations were provided outside typical working hours. This is good.

The front page of *P3pharmacy* magazine the other day—if I could use a prop, I would—says, "Pharmacy First takes off." To give you some quotes from that, "there is also a palpable sense of expectation, and a belief that this is a make-or-break moment for the sector to demonstrate that it can step up to the plate." I thought that was a really nice quote. Ade Williams at Bedminster Pharmacy in Bristol said, "There is a lot of positive excitement around this—it's something we've asked for over a long period. Of course there are logistical concerns—IT is a big one for some—but it's going to be transformative, not just for pharmacy but for all primary care stakeholders."

The front page of *Pharmacy* magazine—the voice for community pharmacy—says, "Pharmacy First, a promising start. The signs are that pharmacists on the ground have made a promising start delivering the service." Jackie Lewis, a pharmacy owner in Exmouth, said, "It was an intense period getting up and running, but there has been a lot of positive energy from local serveries and pharmacies in their primary care network."

Those are good, really good; yet we have various negative voices. I am not saying that they are negative people, but they give a different side to the wider sector. The CCA—Company Chemists' Association—briefing sent to us notes that there are now 1,110 fewer pharmacies in England since 2015. Since the start of the 2023-24 financial year alone there has been a net loss of almost 400 community pharmacies in England. Paul Rees, from the National Pharmacy Association, told the health and politics podcast that I do that 72% of its members are in deficit. He says that the funding model is broken and that a new deal is needed. Finally, Janet Morrison, who is the chief executive of Community Pharmacy England, told us as part of this inquiry that there needs to be a contract framework overhaul to remove the "ironclad ringfence around our funding". That was in evidence that she gave us.

There is really positive press around Pharmacy First and some really positive statistics, yet we have parts of the sector saying, "We're closing. We can't make the sums add up." I am just trying to understand where the truth lies. It is a long question, but it had to have that context. Minister, what are your reflections on all of that and where Pharmacy First has begun?

Andrea Leadsom: First of all, thank you very much for having me again. Universally, I think that Pharmacy First has been welcomed. Over 95% of pharmacies have signed up to it. They did not have to. They are getting a part of a £645 million budget over two years to support Pharmacy First, which includes a £2,000 set-up fee, £1,000 a month, £15 per consultation, and so on. With the IT challenges, I will defer to Amanda to explain exactly where we are on that, but there have been one or two issues. I understand they were not the fault of the relationship between DHSC and the pharmacists. Rather, it was an issue of the pharmacists' own supplier of IT, who has made some changes as a result. That was unforeseen and has slightly delayed the digital connections, but only very slightly.

Pharmacy First is a fantastic initiative. As you rightly say, we are seeing a huge number of new consultations taking place. It is part of a longer-term plan within the NHS long-term plan to see much more clinical service taking place to use the skills of pharmacists. It is a very positive thing.

To your point about closures, the Government are responsible for making sure that people have access to pharmaceutical services. What we are still seeing is that 80% of people live within a 20-minute walk of a pharmacy. There are approximately twice as many pharmacies in more deprived areas as in less deprived areas, which is all good news. Access remains good.

In the year from early 2023 to early 2024, we saw about 1,500 closures and 1,100 new openings. It continues to be a thriving market. Of course, pharmacies are private businesses, and they have a contract with the NHS to provide services. That, therefore, means that things change.

People retire, they want to close, rationalise and so on. In addition, we now have 400 distance dispensing pharmacists, who will deliver to people's homes free of charge. That is a new initiative. If people find that there are temporary queues or that a pharmacy is closed, they will be able to go online and access medicines through those distance pharmacists.

This is a long answer to your long question. The final point is that, of course, where there isn't a pharmacy within a reasonable time or geographic distance, GPs can apply for a licence to open a dispensary themselves. That happens in more remote areas where there isn't a market for a pharmacy to be able to be run in a sustainable way. There are some support payments made to some pharmacies in areas where it is difficult to sustain a pharmacy. The overall package of support and provision remains very strong.

Q179 **Chair:** You are right. There have been a large number of closures and also a number of openings. The gap is about the 400 that I quoted. Is it the case that, given the mixed economy and given that coverage is what it is, as you correctly say, and given that there are online offers, which a lot of young people particularly are more than happy to access, the Government are relaxed if there is some rationalisation in the bricks and mortar estate of community pharmacy? As long as the access is still guaranteed, the Government are relaxed if some private businesses don't make it.

Andrea Leadsom: I would not phrase it like that. What I would say is that the Government are responsible, and take very seriously the responsibility, for ensuring access to medicines for all residents here in England. That is very important. At the moment, we monitor very closely the closures and openings. Of course, integrated care boards have a role in providing licences for new pharmacies, and local authorities have a role in doing an assessment of the needs of their local population. We monitor it very carefully and very closely, but what we are not about is ensuring that a pharmacy never closes or that another one definitely opens. Pharmacies are private businesses.

The whole Pharmacy First initiative, added to the previous increase in pharmaceutical interventions within pharmacies, to monitor blood pressure, provide oral contraceptive advice and so on, is all part of a move to enable many more clinical services to take place in community pharmacies. We believe that will reduce the pressure on GPs by about 10 million appointments a year, just from Pharmacy First alone.

Q180 **Chair:** A million?

Andrea Leadsom: Ten million.

Q181 **Chair:** I am glad you mentioned ICBs. What would your message be to them and primary care networks? Do they have enough pharmacy representation on the integrated care boards, for instance? Are you

comfortable with where that is? Are you comfortable that they are doing the mapping to make sure that there is access to a bricks and mortar pharmacy within X miles of people's homes? What is your message to ICBs about how they should have an overview?

Andrea Leadsom: At top level, I would say to ICBs that primary care is absolutely crucial. It is the thing that every single one of us needs, and that includes pharmacies. It includes GPs. It includes opticians. It includes all the primary care that we all rely on. Some ICBs are very good at scanning across and making sure that the provision is there. Others have perhaps tended to be a bit more focused on emergency care, elective care and so on. It is very important that they ensure that the surveys that their local authorities do of the needs of the local population are taken into careful account. I regularly meet colleagues to talk about issues in their own area. One of the things that has been raised with me is the time it takes for an ICB to agree to give a new licence for a new community pharmacy to start up in a particular area. I urge ICBs to make sure that things like that are fast, and that we are not unnecessarily delaying.

As the Committee knows, there are pharmacies that are owned by the big multiples; there are those that are in a chain of pharmacies; and then there are the small independents. Quite often, if, due to rationalisation or the retirement of a small independent, that leads to a closure, it may well be that there is somebody else willing to come in straightaway and take over that premises to have a continuous flow. I would say that the ICBs should make sure that they address that as quickly as possible, to provide continuity of care for the community.

Q182 **Chair:** That is a very clear message to them. Let's bring in Dr Amanda Doyle from NHS England. It has been said by NHS England that Pharmacy First is something that you expect to see ratchet up and up as there is more knowledge among the public that it is there. Do you expect to see it grow in terms of the number of conditions that it can treat? What is your ambition for Pharmacy First? Where does it go next?

Dr Doyle: At the moment, as you know, the new clinical pathways in Pharmacy First treat seven conditions. They are not necessarily minor conditions, but they are generally uncomplicated and high-volume conditions. We need to embed and establish that and evaluate it. Is it meeting patients' needs? Is it delivering outcomes that mean they don't then need to seek an appointment with their GP? We have an evaluation commissioned around antimicrobial resistance and looking at the total quantity of antibiotics prescribed. Are the pathways the right ones? Are they effective? That is all part of the package that we are quite quickly starting to think about for the future. We are not going to have the outcomes of those evaluations yet.

Q183 **Chair:** How quickly is quickly? You are not concerned, are you, about pharmacists? Some have said that pharmacists will over-prescribe and that will add to our problem with antimicrobial resistance. The evidence

from elsewhere in the world does not back that up. You are not concerned that that is a worry, are you?

Dr Doyle: The evidence does not back it up. The antibiotics can be dispensed by pharmacists according to patient group directions, which are quite tight clinical protocols. An expert clinical group worked them up. NICE guidance is taken into account. They are the same protocols that would usually be in use in GP practices, without the mechanism for it.

I expect that there would be no change in whether a patient gets an antibiotic, regardless of whether they went to a GP practice or a pharmacy, but there is a duty to evaluate that properly. The National Antimicrobial Resistance Board has been involved in looking at how we will evaluate that. It is really important that we do not, inadvertently, contribute. We are not expecting to. We are expecting to gain reassurance, which is particularly important because, as you know, we are concurrently running independent prescribing pilots in pharmacies across the country. We know that all newly graduated pharmacists will graduate as independent prescribers from 2026. Actually, starting this process with Pharmacy First, with a formal evaluation, will absolutely help us to move on as that happens. We are also supporting training 3,000 existing pharmacists this year to become independent prescribers.

Q184 **Chair:** Hold that thought because Rachael is going to come to that in a minute.

Coming back to the money, there has been a 30% real-terms cut in funding since 2015. That is the reality. Janet Morrison leads Community Pharmacy England, formerly the PSNC, the Pharmaceutical Service Negotiating Committee, which negotiates the contract with you on behalf of community pharmacies. She said, "The crucial role of pharmacies in providing essential healthcare services to communities is on the line. The financial pressures on pharmacies are extreme and show no signs of improving." The CPE has "deep concerns about the financial impact of the increase in the National Living Wage" on pharmacy. "It's just not sustainable to expect pharmacies to absorb these additional costs. A failure to act to correct some of this will see many more pharmacies closing through 2024."

Given what I said to the Minister about her call for an overhaul of the contract, and addressing the financial pressures that they face which are leading to closures, how relaxed are you about rationalisation of the bricks and mortar estate?

Dr Doyle: As long as there is, as the Minister says, access for the population, that is the important thing from our point of view. Some of the rationalisation of the estate is when pharmacies are very close to each other. There might be two on the same street. At the same time, we have had a 9% reduction over five years in the number of community bricks and mortar pharmacies. We have concurrently had a 9% increase in distance-selling pharmacies, which offer a service for people who perhaps work all the time when a pharmacy might be open or who cannot

get out or are immobile. We are seeing a balance in a different way of offering a service.

Equally, if our strategy is to increase the role of community pharmacy as a first-line provider of clinical services to the community—which it is—it is really important that we have that estate. We have 80% of the population within 20 minutes' walk of a community pharmacy at the moment. There are twice the number of community pharmacies in close proximity to people in deprived populations. That is really important.

Pharmacy First is a new service, and it is the big one. It is accompanied by big investment. We have slowly been building up a range of other services. Pharmacies now not only dispense all of our medication, but they offer needle exchange and supervise the consumption of smoking cessation and weight management. They do new medicine services for people on complex medicine regimes. They do discharge medicine services. They do significant numbers of our seasonal vaccinations. Pharmacy First, as I mentioned, has a blood pressure service. We have had well over 900,000 people—

Q185 **Chair:** What they would say is that they cannot do it if they are not there. They cannot be your shopfront if they are not there.

Dr Doyle: We are absolutely committed that community pharmacy remains embedded in the community. We look closely at movements in the market.

Q186 **Chair:** That is a good line. Pause there. I will bring in David Webb, and then Rachael Maskell. If I was to produce a risk register for Pharmacy First, I would put medicine shortages right at the top of it, especially how it then interacts with wider primary care. As the Minister rightly said, it is designed to take the pressure off primary care or general practice.

If you go into a pharmacy now to redeem your prescription—something I raised with the permanent secretary and the Secretary of State yesterday, as I am sure you are aware—it is a regular conversation that they will say, "We don't have your item due to national shortages. There is a replacement item, but I can't give you the prescription for that. You have to go back to your GP to get that replacement prescription." That then pushes those people back to general practice. If you talk to GPs they say, "This is happening to us all the time."

Evidence we published yesterday from the Community Chemists' Association is that UK generic reimbursement prices are now so low that manufacturers are prioritising other global markets which they think are more favourable. That then directly impacts on the availability of, and therefore patient access to, medicines. I just want to know from you, as chief pharmaceutical officer, how seriously you take medicine shortages as a threat to the pharmacy sector.

David Webb: Thank you, Chair. I take them very seriously as a threat to the sector. More important than a threat to the sector is the impact on

patient experience and the stress and problems that shortages create for patients.

In terms of Pharmacy First more specifically, because that is a PGD-based mechanism to provide prescription-only medicines, flexibilities were built into the PGDs to allow some movement between formulations if an item moved into shortage. There is an approach within that which enables pharmacists to use their judgment to potentially provide a different formulation if the one that they intended to provide under the PGD was not available. There is an element of flexibility built in to smooth out issues that might otherwise affect the operation of Pharmacy First.

More generally on shortages, there is a significant effort behind the scenes and with colleagues in the Department of Health and Social Care to address situations as they manifest, or before they manifest, as shortages. There is a medicines supply team. There is also a medicines shortages response group. Much of that work is not visible because it mitigates the problem before it manifests.

The important thing is that there is a range of levers available to address shortages in those circumstances. For example, there is a system of providing medication supply notifications graded in terms of the severity of their impact. There are relationships between the Department and suppliers, and with wholesalers, to understand the pattern of medicines use and the nature of the shortage. Ultimately, there are things called serious shortage protocols which enable community pharmacists to supply different products in specific circumstances in response to a shortage.

Q187 **Chair:** They are quite limited at the moment. Is it not the case that the Minister is going to ask Parliament, with your advice, to increase the number of serious shortage protocols?

David Webb: We have seen developments in serious shortage protocols from very narrowly defined tools into things that have a greater range of flexibility to address some of the shortage situations we have had. I can see the scope for enhancing that approach.

The important thing about SSPs in some ways is their precision. They are built on an understanding of what alternative products are available. If there is resilience in the supply for the alternative product, an SSP can very quickly direct towards that. When the initial shortage issue is resolved, they can be deactivated very promptly, while maybe prescribing guidance takes longer to formulate and then to remove. There are some advantages to the nature of SSPs, whereas, as a practising pharmacist, I might not be cognisant of the supply chain situation for all the alternatives. Within an SSP, an assessment is made of the resilience of the alternatives, and therefore they point to products where we will not create another shortage because we have hopped from a shortage situation into another one.

Chair: That is good; thank you for that. Let's bring in Rachael Maskell now on various subjects, not least our workforce.

Q188 **Rachael Maskell:** Thank you. Yes, I want to focus on workforce issues predominantly. We had the privilege of holding roundtables and meeting with the whole pharmacy community. We heard about the funding pressures, which they described, and I urge you not just to leave it to the market but to make some interventions to bring relief there. They also described the workforce pressures that currently exist and will continue for the foreseeable future.

In particular, there is concern around clinical placements for students. With the pressures that pharmacists are under, being able to host students means that a lot of time is taken out. If apprenticeships are to be introduced in the future around the profession as well, clearly that will bring additional pressures. I will turn to Amanda Doyle to start with. How are we going to address the ability to provide good, clinical supervision to our future generation of pharmacists?

Dr Doyle: If we are expanding the workforce, which the long-term workforce plan says we are—we already have been—and we are looking to support pharmacists to develop and extend their range of clinical skills, particularly independent prescribing, it is really important that we recognise not only support for clinical placements for foundation year pharmacists in community pharmacies but in hospitals as well, so that we ensure the pipeline. It is really important that we support ongoing learning and development.

As I mentioned earlier, we are funding pilots of new clinical services through the pharmacy integration fund. We are funding clinical pharmacy leads in each ICB so that there is support for professional leadership and development. This year we funded 3,000 places for independent prescriber training for existing pharmacists. Obviously, we will have a gap if all new pharmacists do it. We want to catch that up.

We recognise the importance of the infrastructure that needs to be in place to support those clinical placements. We recognise that students often need to travel to clinical placements, for example. All of that is part of our commitment to our pharmacy workforce, which extends not just to pharmacists, obviously, but to support for using skill mix more effectively in pharmacies, with better use of pharmacy technicians. There are increasing numbers of pharmacy technicians both in clinical services in primary care or hospitals and in pharmacies themselves. We can free up the pharmacists to carry out a lot of the clinical service delivery that is part of our future strategy for the service.

Q189 **Rachael Maskell:** I will ask you a specific question as you mentioned the ability to undertake placements. Will the Department be looking at introducing the learning support fund, which is applied to other health professionals like nursing AHPs, in order to help facilitate the profession? Can I come back to you, Amanda, on that whole workforce development

in NHSE?

Dr Doyle: For pharmacies outside the scope of the learning support fund, because it applies only to courses that were eligible for an NHS bursary prior to 2017, I cannot answer as to whether the Department will be looking to extend that. That is not an NHS England decision.

Q190 **Rachael Maskell:** Perhaps I can turn to the Minister on that point.

Andrea Leadsom: The straightforward answer is that these things are always under review. At the moment, I am not currently aware that there is a plan to extend it.

Q191 **Rachael Maskell:** I would like to turn to a more substantive issue, looking at what you have described around different professions in the pharmacy community taking on different roles. There is real concern, as we see more skill mix, that there is blurring of the professional boundaries between the different professions, and that this brings into question how that is being addressed, not only through the prism of patient safety but also regulation, to ensure that we see regulation addressing the different competencies that are attained and we do not see skill drift or, indeed, people working above their competencies. How is the Department looking at the whole issue around expanding roles, both to ensure patient safety and to maintain very clear and distinct clinical boundaries between the professions?

Andrea Leadsom: Are you addressing that to me?

Rachael Maskell: I am addressing that to you.

Andrea Leadsom: That is absolutely integral to everything we do. Patient safety is absolutely key. You are quite right that what we are trying to do is to improve access for patients, and therefore to enable different clinicians to be able to work to their training levels. In the past, they have not necessarily done that. We have seen that with dental therapists, and we see it with pharmacists. In fact, there is some secondary legislation coming through. I have a feeling it is in mid-April, but don’t quote me on that. It is to expand, but very carefully, the role of pharmacy staff to be able to take on more, in a very controlled way.

I really want to assure anybody who has dialled into this that patient safety absolutely comes first. There will not be skill drift. This is about improving access and making better use of what are superb clinical skills in community pharmacy. First, that is because it is closer to the patient; as I said, 80% of people live within a 20-minute walk of a pharmacy. Secondly, it is because those skills are available and have, in the past, traditionally been under-utilised. This is not about, in any sense, dumbing down. It is not about skill drift. It is not about any risk to patient safety. It is about improving patient access to those skills.

Q192 **Rachael Maskell:** One of the key things around regulation is the title of a professional and recognition of that title. That enables and empowers

the patient to understand the services that they are getting. How is that being communicated to patients, if we see an increase in the range of competencies that clinicians are working to, so that they understand the parameters of the care that they are receiving?

Andrea Leadsom: There are two answers to that. The first is the patient's perception and the patient's own control of their own care. The other is the reality of it. From the Government's point of view, there will obviously be very strict patient safety-focused controls around what different clinicians are able to do. A key part of the Pharmacy First IT upgrade was to ensure that pharmacists would be able to access patient records, so that any prescribing done by a pharmacist would be in full knowledge of any allergies, intolerances or other prescriptions. That is the control aspect of it, top down.

The patient's own awareness is obviously very important too. There are a number of different public health campaigns. We have done a lot of media around the new Pharmacy First and the ability to go to a pharmacy and be treated for seven common conditions. That is, if you like, putting power into the hands of patients. They can say, "Actually, I could call the GP surgery and perhaps not see someone for a couple of days, or I could pop into my high street pharmacist and see somebody there, who is perfectly able to prescribe for me something for my sore throat or my earache." It creates patient choice. It improves patient access, but there is no compromise in terms of patient safety.

Q193 **Rachael Maskell:** I have a further question. Clearly, if people are working with new competencies that will be granted with the regulations—I will have a look at that—how will those posts be evaluated against the Agenda for Change job evaluation scheme?

Andrea Leadsom: Is that a question for you perhaps, Amanda?

Dr Doyle: Is that posts within pharmacies?

Rachael Maskell: Yes.

Dr Doyle: The Agenda for Change system is in use for NHS employers. Most of primary care does not use the Agenda for Change system. General practice tends not to, pharmacies do not and nor do dentists.

Q194 **Rachael Maskell:** With the roles themselves, a pharmacy technician can work in a hospital pharmacy as well.

Dr Doyle: The information that is used in the hospital sector, for example, to evaluate the role of a pharmacy technician is openly accessible to people introducing that role in a community pharmacy or another primary care provider who want to receive some guidance. Ultimately, responsibility for deciding pay rates is with the employer.

Q195 **Rachael Maskell:** There could be a number of jobs needing re-evaluation, clearly, if they are taking on more competencies within their brief.

Dr Doyle: That's right. As we develop roles, introduce new roles and introduce extensions to roles, some people's jobs will require re-evaluation.

Q196 **Rachael Maskell:** I want to pick up an issue which I have heard thematically throughout our inquiry. It is around Pharmacy First and the discussion we have just had. We now see pharmacists expanding their role and providing diagnoses in certain conditions, while we also see doctors' involvement in prescribing being quite extensive, including drug reviews and people often having to go back to a GP for sign-off, or with the provision of alternative medicines, going back to a GP before a pharmacy can dispense. David, we seem almost to be flipping roles as opposed to focusing on the specialism pharmacists can provide. Is there more that can be done to ensure that there is a distinction between the professions, and that we are getting the maximum value out of the professional competencies that pharmacists bring?

David Webb: This partly goes to the concept of a one workforce model within an integrated care system, in the sense of knowing what each partner is contributing and, specifically in the pharmacy arena, understanding what each sector of pharmacy contributes. It is moving beyond an identity that is defined by your sector of practice to one that is more defined by your clinical contribution, wherever you choose to deploy it. With Pharmacy First, there is a very specific set of clinical conditions.

Q197 **Rachael Maskell:** It could expand.

David Webb: It could expand. It is a great platform for the future. It is a great way to express to the population what it is about. It is a very defined set of clinical conditions. We have worked with expert groups, multi-professional expert groups, to look at the treatment options and then how those are phased, depending on the presentation of the patient.

The point you make about messages going back to GPs for providing alternative products often relates to a shortage situation. In the absence of an SSP, a community pharmacist has to dispense what is on the prescription.

Q198 **Rachael Maskell:** A pharmacist would probably have greater competencies within pharmacology than a general practitioner. It is how we maximise the relationship, not just uni-professionally but integrated across the professions. That is really important.

David Webb: That is the essence of the one workforce thinking. The other relevant point is that we have pharmacy professionals working in general practice or in PCNs as well. There is an element of co-ordination through that which can be enhanced as the pivot between different parts of the pharmacy provision in a given geography.

Q199 **James Morris:** The direction of travel with Pharmacy First and myriad other things is to expand pharmacy and expand access, but the premises themselves are largely set up as retail premises. We have had evidence

that there is quite a lot of variability across the pharmacy estate in relation to consultation rooms and other infrastructure. David Webb, have you done an evaluation of the adequacy of the pharmacy estate to deliver the different services that are in Pharmacy First and thinking about potential future expansion? Has there been an evaluation of the estate and its capacities?

David Webb: The requirement on community pharmacy is to have a private consultation room where the participant and the professional can hold a conversation without a risk of it being overheard by other people. That is an absolute requirement. That must be in place as part of the contractual arrangement.

Q200 **James Morris:** Does that get monitored? How do you know whether or not that happens? Is there going to be an inspection regime or some way of determining whether somebody is fulfilling that element of their contract?

Andrea Leadsom: It is a legal requirement.

Q201 **James Morris:** It is a legal requirement?

David Webb: Yes, it is a legal requirement to have it. If there were ever concerns, they would be addressed at ICB level through the usual performance mechanisms.

Dr Doyle: Pharmacy commissions are delegated to ICBs now, and each ICB is expected to have an understanding of their estates and a strategy for their estates, including primary and secondary care. That includes everywhere we commission clinical services from. Increasingly, that includes pharmacies.

The challenge is real. It is a requirement of the contract that the pharmacy can offer a private consultation room where people can either have a consultation or discuss an issue, where both the pharmacist and the patient can sit down. Pharmacies will always have access to computer records and a patient's national care record, for example. In future, more of the clinical record will be available in that room.

As we look to expand clinical services rapidly—pharmacies are taking up the opportunity, as you heard from the various reports at the beginning—for lots of pharmacies that means more than one room. Part of the set-up payments for things like Pharmacy First is not just about training the staff and getting yourself ready, but ensuring that you can deliver the services that you want to take on from an estate and infrastructure point of view.

Q202 **James Morris:** What element of that set-up fee would be about investment in the premises?

Dr Doyle: It is not broken down that specifically. Obviously, it will vary so much from pharmacy to pharmacy. The big multiples, which might be in a big store, can repurpose space much more easily. It is up to individual pharmacies to meet their needs.

Of course, because pharmacies are also commercial premises they differ from general practice in that general practitioners are not allowed to offer private services to their registered patients. Lots of pharmacies might offer a travel vaccine service, for example, for which they maintain a consultation room. They are generating income. Alongside that, they also increasingly offer NHS-commissioned clinical services, for which they also require that space.

Q203 **James Morris:** Minister, on the basis that the premises are going to become more important as we want to put more services through them, we have heard an argument that pharmacy should have an establishment fee beyond the set-up fee, so that there is actually a contribution to their capital investment from the Government.

Andrea Leadsom: There used to be an establishment fee, and that was phased out some time ago.

Q204 **James Morris:** Do you think there is an argument for bringing it back?

Andrea Leadsom: Personally, I think the basis on which pharmacy is a private business with a contract with the NHS is the right approach, so that those private businesses can offer other services to members of the public. I don't think it is right that the taxpayer should take on the burden of updating or upgrading those premises.

Pharmacy First is a very good example. Almost all pharmacists have taken up the Pharmacy First contract. They have decided to do that, and they received a £2,000 fee to help them get up and running. They are receiving £1,000 a month. That was obviously attractive. As Amanda says, that could perhaps be used to clear space in an existing room to create a consulting room or an additional consulting room. It could be used to redecorate it.

Q205 **James Morris:** Would you accept that the nature of the pharmacy set-up, as it has traditionally been, may well be a barrier to future expansion of services? We have Pharmacy First where we are directing a number of clinical pathways into pharmacy, but there is going to be a barrier or a cap on what is possible in the way in which pharmacy premises are currently configured.

Andrea Leadsom: That will be some and some. In a major huge store, where pharmacy is one element, there may be room to expand that significantly if the demand is there.

I go back to the fact that local authorities do an assessment—I think it is every three years—of the needs of their population. It is for ICBs then to facilitate the opening of a sufficient number of community pharmacies. I would say that the downside of that is that if a pharmacy has closed because the owner has decided to retire or to rationalise a number of stores in a chain, you end up, unfortunately, with a period when the one or two remaining pharmacies in the area have queues. I hear a lot about that from colleagues as well as from constituents. I have had those issues

in my constituency too. It is then for the ICB rapidly to ensure that anybody else who wants to apply can get a licence quickly. I do not necessarily think we should be changing the model so that, somehow, we end up where the taxpayer is taking on the burden of upgrading premises to deal with the changing facilities.

Equally, with the seven common conditions, at the moment and for quite some time we will see that there is the capacity within pharmacies to deal with those consultation opportunities. As I said, they receive a payment of £15 per consultation, so that is additional income. That is potentially saving up to 10 million GP appointments a year. It is a good story overall, but I would not accept that the taxpayer should pick up the bill for upgrading individual pharmacy premises.

Q206 **Chair:** There were, obviously, perverse outcomes of the establishment fee, in that you got clustering, which is not necessarily helpful to anybody. I wonder whether a more targeted fund to help community pharmacies exist and, therefore, make the most of Pharmacy First may be something that NHS England and the Government might consider. Yes, there is an up-front payment and an ongoing payment, which is not ungenerous, but you have to think of the expenditure required to buy some of the kit. For instance, traditionally pharmacists would prescribe something over the counter for an outer-ear infection but, as I understand it, they can now prescribe something for an inner-ear infection. You obviously need the right piece of kit—the non-clinician in me does not know what it is called—and you will have to buy that piece of kit. That does not come for free. If they are a multiple and they have access to funds to make that kind of investment, happy days. If they do not, I wonder whether there could be something that they could tap into, and whether that is something you would consider. It is more targeted, I guess.

Andrea Leadsom: There is the availability of financial support for pharmacies in areas where it is very difficult to maintain a business. I think that is probably relatively sparingly used. One of the key reasons for Pharmacy First being only seven common conditions is that there needs to be a bedding-in period. You would not want to open the floodgates and then find that pharmacies have queues of people looking for appointments for various things.

It has been a very careful and measured roll-out of something that is just wholly good news for patient access and patient provision, while at the same time not overloading pharmacies and recognising some of the points that James and you make. If you need to buy pieces of equipment—

Q207 **Chair:** It is called an otoscope. I have remembered it now. That is what looks in the ear.

Andrea Leadsom: Yes, exactly. It is a very valid point. Obviously, we literally rolled out Pharmacy First from 31 January. There are still one or

two teething issues with the technology, which I am sure Amanda can fill the Committee in on. It is still early days, but the evidence is good that so far it is a success. It has been welcomed.

I have had a few letters from colleagues with constituents who were passed back to the GP, and then back to the pharmacy. That is not desirable, but obviously it is very early days, and we expect those sorts of things to settle down. It needs to be very carefully monitored. Issues like the structure of the pharmacy itself, the need for equipment and so on will be under careful review.

Q208 **Rachael Maskell:** You said there were 50,000 appointments in its opening concept, yet your ambition is 10 million. That is a two hundredfold increase. Clearly, if people are going in such volume to see their pharmacist, there need to be other facilities made available, for instance for waiting. We are talking about people who are poorly. I have seen people queuing up in the street to go and see their pharmacist. What consideration would there be around providing better care for individuals who are going to Pharmacy First? That again makes the point around some form of establishment fund to ensure that the premises are fit for purpose and that not just the service but the care is available for patients.

Andrea Leadsom: You make a really good point. Of course, that will be carefully monitored. I didn't say 50,000; that was actually the Chairman, so not my numbers. The modelling was to try to get to freeing up 10 million GP appointments a year. That is where the £645 million came from. It was worked backwards from the target number for freeing up GP appointments. That, of course, was looked at with capacity in mind.

There is a target. I was just trying to find it, but perhaps one of my colleagues has it. I think in the first month of operation it was one consultation. In March it is five consultations. Then each month it rises, to something like 1,000 consultations a month. Is that right, David? Would that be about the number?

David Webb: I am not sure it is projected that far.

Dr Doyle: There is a real issue. It has been running since 31 January, so maybe eight weeks. We started off with relatively low expectations of the numbers that community pharmacies could deliver in the first few weeks. That rises really rapidly up to the maximum capacity we would expect to be able to get from pharmacies in October. In advance of winter, we hope to be at the maximum.

We have just short of 10,000 pharmacies taking part, all of which, as we have heard, are enthusiastically embracing this. We had a media campaign that launched in the middle of February and finishes this week—TV adverts, radio, billboards and so on—letting the public know. We deliberately delayed that for six weeks because we did not want everybody turning up on the first day. This is the sort of service that,

once people know about it and get referred by their GP once, maybe they will try again straightaway next time. We want to let pharmacists get their systems embedded and get the staff used to it. Then we will ramp it up.

Q209 **Rachael Maskell:** My particular point is that clearly if there is high demand, which is obviously what you are looking to, the care of those individuals is really important—for instance, waiting for their appointment or to see a pharmacist—because they are poorly and they are queuing down the streets at the moment. We need to make sure that proper facilities for that are made available.

Dr Doyle: All those aspects are part of the evaluation of the scheme. At the moment we have had really enthusiastic uptake from pharmacies. We have had really positive feedback generally, from pharmacists and patients. We need properly to evaluate the numbers and what the feedback is telling us, and then review our ongoing approach.

Chair: Obviously, within the seven conditions there are some, such as infected insect bites, that will not be big news now, but that will happen as we get towards the summer, so that makes sense. We said that this inquiry is about community pharmacy, but we are also interested in the secondary sector and hospital pharmacy, so Paulette Hamilton will touch on workforce, I think, but also hospitals.

Q210 **Mrs Hamilton:** I just want to ask one question about the workforce. Rachael covered it quite well, but I want to ask the Minister and David about concerns over the extent to which pharmacy technicians are being pushed into the frontline of pharmacy clinical practice. It is buzzing out there; people have concerns.

We have heard today about the Government wanting to give parity of esteem to pharmacy technicians. The clinical responsibility being given to technicians was previously undertaken by pharmacists who have the underpinning degree that technicians, no matter how you upgrade them and send them on courses, do not have. My concern is that technicians are being represented to the public, and to parliamentarians, under the generic term of "pharmacy professionals". I believe that is blurring the lines.

What happened with the issue we had the other day about physician associates—I hope I have got that right—was that after a little while the roles were blurred and it created a problem. I am concerned that what we are trying to do with pharmacy, the pace it is going and what we are asking of technicians, is just too much at this point. What are you going to do with the independent practices that have people lining up outside to come in, and that do not have enough staff? Pharmacy technicians are asked to do more and more, and may be doing more than they are qualified to do. How are we going to stop the same thing happening in pharmacy that happened with doctors? I will start with the Minister, and then hand it over to David.

Andrea Leadsom: All I would say to that is that patient safety is absolutely paramount and, as I have already said to Rachael, there isn't blurring of the edges. There is not an intention, or even a carelessness, that would enable pharmacy technicians to start practising above their training. The idea is to improve patient access and patient convenience while retaining patient safety and therefore to make the maximum use of the training levels of different professional people. It is extremely unhelpful when parliamentarians suggest that this is some kind of wild west or free-for-all, because that simply could not be further from the truth. Perhaps, David, you would like to provide more reassurance on that.

Q211 **Mrs Hamilton:** I am not saying it is the wild west. Let's just get it out there. This is coming from pharmacists. We recently had an issue with doctors and associates. At the moment we are pushing this down the road. Are we listening to what pharmacists are saying? It is not the wild west. I have known you for years. Don't do the jibes. At the end of the day, there is an issue. Answer the question: don't jibe at me, please. Thank you. David?

David Webb: I hope I can provide some reassurance on those matters. On the first point you mentioned, the reason for the framing of the collective term "pharmacy professionals" is that both professions—the pharmacist profession and the pharmacy technician profession—are regulated by the General Pharmaceutical Council. Both professions are under regulation. That is an important backstop and an explanation of the patient safety context in which we operate. These are not unregulated workforces. They both have to be registered with the General Pharmaceutical Council to practise, and are subject to the fitness to practise standards that the regulator imposes. That is the first level of reassurance.

The second level of reassurance, where we are looking to enable skill mix to operate properly in pharmacy, is that the Department of Health and Social Care has just completed its consultation on pharmacy supervision and is considering the responses. That sounds a little dry, but supervision has a very specific meaning in the world of pharmacy. It is framed in the legal description of what activities must be undertaken by a pharmacist and what may be undertaken by other people. That is a very unusual position to be in. In most professions related to medicine, the bulk of that definition is held in regulatory standards, not in law. The Department has consulted on changes that would enable supervision to be more a matter of regulation and professional standards than of law, because case law tends to interpret supervision very narrowly, so that someone must almost be looking over what you are doing, when the purpose is to put safe systems of operation in place, and have a framework of governance to enable someone to operate effectively, as well as delegating certain tasks appropriately to other people.

That consultation has just closed. It attracted a lot of response. I think the Government will consider their next steps in relation to that, but I suspect that the consultation may have triggered some of the feedback that you have heard, from pharmacists in particular.

Q212 **Mrs Hamilton:** There has been a lot of feedback.

David Webb: That is the second level of reassurance. Both are in regulation, and there are changes to supervision, but those changes relate to operational processes such as the assembly and dispensing of medicines. The bit that it is important for the pharmacist to do is around the clinical judgment as to whether a prescribed item is appropriate or not. That bit is not threatened by the change. The change, if it goes ahead, is about enabling oversight of the technical elements of a process to be appropriately delegated—if you accept that terminology—to registered health professionals who can then undertake it on behalf of pharmacists. It is not about blurring the clinical interface that the pharmacist may have with the patient in a consultation.

The other thing I ought to mention is that quite a lot of the debate—you may have picked this up—has been about entry-level qualifications, and not the qualifications one develops over one's career, the better to discharge one's responsibilities. You may be aware that the Department has been considering a consultation that recently closed about the ability of pharmacy technicians to join the group of healthcare professionals who can operate under PGDs. Again, it is not about day-one roles, but roles that someone develops into through a course of professional development, which can be undertaken at some point in the future when they have the necessary knowledge, skills and qualifications. To reassure pharmacists and the public more generally, it is about appropriately skilled people being empowered to do the right thing. It is not about blurring boundaries.

I am sorry—this is a long answer; but I want to conclude on the point about identity. I am not sure if that was from you, Rachael. How do the public know who they are dealing with? There is an important element to this.

Q213 **Mrs Hamilton:** It is massive.

David Webb: There is an important element to do with people wearing badges or other indicators defining the role that they provide, so that the public know who they are speaking to, when they enter any premises. My background has largely been in hospitals, and a great deal of effort goes on there to make name badges. They have contrasting backgrounds so that people with poor sight can see them. They are suitably large. They describe who you are and your contribution to the multi-professional environment that we all work in.

Q214 **Mrs Hamilton:** Just to end this question, as I do not have very long, Healthwatch England has also voiced concerns in this area. My last word

would be, please let us work together and listen to what other people are saying, to ensure that we do not make the same mistakes that were made with the doctors. Let's start the way we mean to go on and not push people into doing things that perhaps they are not ready to do, or that could lead us down the road to where we are with the doctors now. That is the only point I would like to make.

I will move swiftly on. Minister, please, what is NHS England's ambition for the future of hospital pharmacy?

Andrea Leadsom: I am sorry to say that that is actually not my portfolio. I will defer to Amanda to talk about the future ambition.

Q215 **Mrs Hamilton:** Thank you. Amanda.

Dr Doyle: Without wishing to appear unhelpful, it is also not my portfolio. I am primary care, but obviously it is a pathway, isn't it? Patients go in and out of hospitals and receive medicines across both. If it is a question of technical information about what happens in hospital pharmacies, David is the expert. If it is about things like discharge medicines, I am happy to pick it up.

Q216 **Mrs Hamilton:** I will tell you where I am leading. We went to the Cleveland and saw some really good work, such as the closed loop medical system, the bar-coded medication and the automated dispensing cabinet. It was absolutely excellent. What I would like to know is where the rest of the NHS is with all that. I would love, before I die, to see it across the NHS. It was an excellent exemplar.

David Webb: The good news is that those facilities are available in some NHS trusts now. There are 11 global digital exemplar NHS trusts that have some form of closed loop. The closed loop approach to provision of medicines is the process you would have seen at the Cleveland.

Q217 **Chair:** Presumably Frimley would be one of them.

David Webb: Cambridge University Hospitals is a very advanced demonstration of that process. It is good news that we have that sort of ambition within the health service. It has been spurred on, I think, by local champions, and to date we haven't had a more systematic approach to things like automated medication storage and robotics. That can be contrasted with the sort of investment that has been made in electronic prescribing and medicines administration systems, which is part of the same story. The powerful thing about the bar-coded medicines administration that you will have seen is the ability to scan the patient and the product; then the electronic prescribing system tells you that there is a match between your intended recipient and the product that they should receive.

The other thing that Cleveland will do is unit dose dispensing—the packaging of individual doses. That is not really an NHS approach to the provision of medicines at ward level. We are much more focused on providing original packs of medicine—outers of 28 tablets, for example—

because unit dosing is very labour-intensive. I think Cleveland probably requires 24-hour verification of all doses that are about to be administered. It has a significant workforce consequence if you expect someone to verify every medicine remotely before it is administered. The important parts of what you have seen about the closed loop element have direct relevance to the NHS. Of those 11 global digital exemplars, at least another four or five trusts are not part of that group but have also instituted closed loop processes.

Q218 **Mrs Hamilton:** To move this on a little bit before I hand back to the Chair, to what extent are designs in new hospitals considering pharmacy infrastructure like we have just talked about?

David Webb: There are two important connections with the new hospital programme. One is exactly what you mentioned around automation and the use of automated cabinets in clinical areas, as well as dispensing robots in pharmacy areas.

The second element that is relevant to the new hospitals programme is the aseptic services transformation, which is an initiative to provide, from regional hubs, more medicines in a ready-to-use form that can be delivered to hospitals and taken to clinical areas. The product is ready to go and does not involve the nurse having to manipulate and reconstitute, as we would say, a mix—a dry powder injection with a diluent—to create the injection or draw it up to give an infusion. It presents it in a ready-to-use form. There are big advantages around reducing error, and in liberating nursing time to focus on direct care for patients rather than being in preparation rooms making infusions and injections to be administered. Those two things are being considered in the new hospital programme—the automation and the need to be able to accommodate ready-to-use medicines in clinical areas that might come from regional aseptic hubs.

Mrs Hamilton: I will stop you there and hand back to the Chair.

Q219 **Chair:** It is interesting. The thing about being a Health Minister, as I remember, is that everyone has their portfolio but everything is also everything else, as you well know.

Andrea Leadsom: Yes, absolutely.

Q220 **Chair:** Which is why it is so exhausting. Imagine being Lord Markham, who has everything in the other place. You understand the challenges of getting the meds right in getting people out of the acute setting. That, of course, is as much primary care as secondary care, because it becomes that issue. How are we getting on with the idea of having a pharmacist in all emergency departments? The Royal College of Emergency Medicine was very keen on that, and pushed it as a campaign. Are we getting anywhere with that? Does anyone know?

David Webb: We have access to the NHS benchmarking network information from acute providers. On that topic, about 45% of hospitals

that responded said that they had a clinical pharmacy service in emergency departments. It is not universal but it is a significant step towards the provision that the Royal College of Emergency Medicine recommended in its guidance.

Q221 **Chair:** Okay. I have a couple of final things for the Minister, and then I will see whether colleagues have any final thoughts.

Hub and spoke, Minister: the Government did a big consultation called "Hub and spoke dispensing", which closed at the end of September last year. For those watching who may not be total experts on this sector, what do you understand hub and spoke to be, and what are you being told by your officials as to when, or if, we will see any response to the hub and spoke consultation? A lot of work went into it.

Andrea Leadsom: Yes, absolutely. Certainly, the ambition of hub and spoke is to make the dispensing process more efficient and thereby free up pharmacists' time. At the moment, hub and spoke is already allowed within the same legal entity, but there has been a consultation to enable hub and spoke dispensing between different legal entities. That took place in 2022. I fully expect to publish the Government's response to that consultation shortly. I have not seen the collated analysis on hub and spoke, but I have talked to colleagues who come to me with issues such as a chain of pharmacies that are not all within the same legal entity, meaning they cannot use the hub and spoke model, which they find has useful economies of scale, within a store or stores that are not part of the same legal entity. In principle, I think there will be advantages to it. Clearly it is designed for efficiency.

Q222 **Chair:** Given all the changes that we have talked about—workforce changes, supervision and, not least, Pharmacy First—is hub and spoke biting off a little bit more than the sector can chew right now?

Andrea Leadsom: It is already used and has been in place for some time, so the consultation is only on whether to allow the same model to exist where there is a branch that is not in the same legal entity. I do not think it would be a revolution. It would be an incremental improvement in the process that enables efficiency. At the end of the day, it would be about time saving and better use of resources, but, as I say, I have not seen the collated response to the consultation, although perhaps you have, David.

Q223 **Chair:** Any thoughts, David?

David Webb: Nothing further to add, Chair, at this point. It is under consideration—I think that is the phrase—at the moment.

Q224 **Chair:** Finally, from me, Minister, NHS England announced something called community pharmacy cancer pilots in June 2022. That was described as "radical action" on early cancer diagnosis, and it was about trialling community pharmacy direct referrals to diagnostic services, as I understand it. Amanda Pritchard, the CEO of the NHS, launched it at the

Confed Expo in Liverpool in '22. Where are we with that? It feels like quite slow progress. I think fewer than 10 pharmacies are signed up to that pilot. Is it still something that you are keen on? Could you update us?

Andrea Leadsom: Yes, it is definitely something we are keen on, but of course it is a pilot. It is designed to improve that pathway. The question is whether it will work. Is it going to be a successful way to identify people and get them on a cancer pathway sooner, or will there be lots of false positives or, indeed, reassurance to a patient where there should not have been? I will leave Amanda to talk through the details.

Q225 **Chair:** What is the thinking? Is it that pharmacists are the shopfront? They see people all the time who may come in with a regular, persistent cough, looking for a cough linctus, and that may be a flag, so they make a referral. Is that it, crudely put?

Dr Doyle: That is what the thinking started with, yes. Essentially, as I said earlier, we have twice as many pharmacies in deprived communities as we do on average across the country. People living in deprived communities are significantly more likely to have their cancer diagnosed at a later stage. For those communities it is probably important that we take any opportunity at all to pick up worrying signs and symptoms early and get people on the right pathway. That was the initial thinking.

The pilot has started. We have not worked it up in detail and then rolled it out, but there are four pilot sites in total. Cornwall and Norfolk have started, to be followed quite soon by Greater Manchester and south-east London. The initial work has been on which cancers are most likely to present in this way; what the pathway is; what list of symptoms we should look for; and how that links to the local cancer pathway. What is the mechanism by which community pharmacists refer in, having flagged the symptoms?

The thinking is that all the pilots will focus on lung cancer. It is absolutely the example you gave: people who keep coming back for something for a cough. That is a flag. There are two other pathways that some but not all the pilots will be testing. One is head and neck cancers—someone who keeps coming back with a recurrent sore throat, swollen glands, or a sore mouth. It is people who have symptoms that as a one-off are fine when they present to the pharmacy for one-off advice or over-the-counter treatment, but if the person keeps coming back with those things, it raises a red flag. The other group is gynaecological cancers. People might ask whether something is a normal side effect of their HRT, or those sorts of questions. Symptoms that are flagged to pharmacies more commonly than others might be a good pathway in.

Work is ongoing. We have to get it right. This is not about replacing GP surgeries with pharmacies, or passing people around to different services. This is about opportunistic identification in high-risk places of people who might have worrying symptoms. Don't forget, our aim is to have a really

low conversion rate for cancer pathways. We want many more people to be referred in than actually have cancer. That is the best way not to miss cancers, and to get them diagnosed at an early stage when they are treatable and potentially curable. That is where we are up to.

Chair: Interesting. Do any colleagues want to come back in?

Q226 **Rachael Maskell:** I have one further question for David. This Committee gets very excited about looking into the future and at what is coming down the stream, particularly because we know that it can have a transformative impact on patients and their futures. I asked a parliamentary question about the use of AI in pharmacy and got the response that the Department was not looking at those areas at the moment. Could you perhaps set out what the future technological landscape looks like, and in particular how AI could be deployed in the profession?

David Webb: Yes, I am happy to speculate a bit on the future. The technology elements run from the things we talked about previously; the automation and the digital systems that support that. Once you encode information within a digital system, you create a rich environment for processes like AI to interrogate data and look for patterns within that.

There is probably a fundamental clarification to make, between what we might call decision support and AI. Decision support is the sort of thing that guides you to the right dose or the right adjustment if someone has renal failure—those sorts of things; whereas AI is a bit more liberating in the sense that it can kind of crawl through the data and identify patterns for the future. I think that the sort of records that pharmacists keep about the dispensing of medicines and the presentation of illness will be a ripe area for that, as it has been in medical practice, where it is used to interrogate radiographic images and provide diagnostic advice to clinicians that seems to be of a very high standard. I think it is part of the future. It probably joins things like genomics as well, in terms of the predictive element.

Healthcare can be quite reactive, can't it? It can intervene and then see what the response is. I suppose what I am saying is that in the new era things like AI will predict the kind of response we see. Genomics will predict our response to medicines, so it will not only tell us the precise medicine that we need, but will help us avoid adverse reactions, because we will know the genetic make-up that predisposes someone to an adverse reaction. In the round it is a very exciting future. When you couple that intelligence aspect with the automation and the digital systems that underpin it, I think we are on the verge of something transformative.

Andrea Leadsom: Can I add to that? I completely agree with you. I talk to GPs who worry about the number of medicines that people take, particularly in an ageing population, and I think AI could be incredibly useful there. I was talking to some GPs recently who said that the trouble

is that you give someone a drug, and then you give them a drug to offset the side effects and, before you know it, they are on a cocktail of drugs. Sometimes sight is lost of quite how many drugs people are supposedly taking. Then the patient decides, "Actually, I'm not going to take all of those. I'll just take some of them," which is potential disaster. I think AI has a really important role in constant drug review—medicines review—to make sure that someone is not being overloaded unnecessarily.

Rachael Maskell: Fantastic. Next time I ask the question I expect a different reply, and to know that the Department is investing in this technology. Thank you.

Chair: When Rachael says we get excited about something, everything is relative in life. I think I should clarify that. We get excited about lots of things, not least you coming in to see us, Minister. Thank you very much for coming in, Andrea Leadsom, David Webb, chief pharmaceutical officer, and Dr Amanda Doyle of NHS England. It was really nice to see you all. That concludes our inquiry on pharmacy. We will now produce a report, which I hope you will take a look at when it lands on your desk. That's it for today. Have a nice Easter, all three of you.