



Public Services Committee

Uncorrected oral evidence: Medicines security

Wednesday 22 October 2025

11 am

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Members present: Baroness Morris of Yardley (The Chair); Lord Bradley; Lord Carter of Coles; Baroness Cass; Lord Laming; Lord Mott; Lord Prentis of Leeds; Lord Shipley; Baroness Wyld.

Evidence Session No. 2

Heard in Public

Questions 15 - 32

Witnesses

[I](#): Claire Foreman, Director of Medicine Policy and Strategy, NHS England; David Simmons, Director of Supply Resilience and Medicines, Department of Health and Social Care; Andrew Howard, Deputy Director of Manufacturing, Skills and Partnership Delivery, Office for Life Science.

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Examination of witnesses

Claire Foreman, David Simmons and Andrew Howard.

Q15 The Chair: Welcome to this meeting of the Public Services Committee in our inquiry into medicines security. I welcome our witnesses and ask them to introduce themselves.

Claire Foreman: Good morning. I am the director of medicines policy and strategy at NHS England.

David Simmons: I have been the interim director of medicines since the summer. I also have another director role in the department, which deals with medtech response and other supply issues.

Andrew Howard: Good morning. I am a deputy director in the Office for Life Sciences. I am responsible for manufacturing skills and partnerships delivery.

The Chair: We are grateful for your time today. This is a complicated area but, hopefully, we will make progress. I suppose you cannot do much about this problem unless you know that there is a shortage or can predict that there is going to be one. I want to explore the information you have about the supply of medicines. I ask you to reflect on whether you think that has changed over recent years. Is where we are now different from, perhaps, had we done the inquiry 10, 15 or 20 years ago?

Andrew Howard: That is probably a better question for David to answer.

The Chair: Okay; I am happy for him to do that.

David Simmons: I am happy to start on that one. To answer the final question, the information that we have is much stronger than it was 10 or 15 years ago. Part of that is due to the policies that have been put in place to get the information, but it is also about industry relations. We are much closer in our relationships with industry than we were, and it is a far more trusted relationship.

On shortages, in the early 2020s, we introduced a discontinuation and shortage portal. That is a formal requirement in legislation for marketing authorisation holders and suppliers to report to us where there is a potential disruption to any of their products; they are meant to do this with six months' warning or as much as possible. That is our main source of intelligence about shortages, and I am sure that we will talk about the data that that is showing us later on.

Since the introduction of that, people have been getting more and more used to it. It has been the main source of data on shortages, and we have been using that information a lot more. Not only does it tell us the number of shortages that are reported; it also tells us the products that they relate to and the causes, as reported by those suppliers. So we have been doing a lot more analysis of that.

The DaSH—discontinuations and shortages—portal is the main source, but that is supplemented with a lot of other evidence. Sometimes, evidence will come up through the system—through the NHS and other healthcare professionals—to report a shortage to the department. We take those seriously. You can see things in the media where we investigate because, if we have not heard it from another source, we still take that seriously and look at it.

As I say, the relationships with industry are very strong. We receive a lot of information from industry on concerns about things that might be happening or that we should be aware of, which is really helpful in getting us on the front foot. Then we have significant networks across government, because, although the shortages or supply issues are sometimes specific to a medicine, they can often be things such as disruption in the Red Sea or a trade restriction put in place somewhere across the world. Others across government would have initial intelligence on those issues but, if they share it with us, we can then look at how that is important for products and which products we get from that area.

There are a lot of different sources of information. Obviously, whenever we get a piece of information, we try to triangulate it. If we see something in the media, we look to triangulate that by talking to the company and others. If we get something about an external threat from another department, we look to engage with industry on it. It is about trying to triangulate that information. As I say, a lot of the systems that I talked about, some of which are very formal and some of which are more informal, were either not in place or much weaker, in my view, 10 or 15 years ago. So we are not perfect in any way, but I hope that that gives some confidence that a number of different sources have been developed and work relatively well to identify shortages.

- Q16 **The Chair:** Claire may want to come in on this but, first, I have a little extra question, rather than you repeating what has been heard. What has been described is quite complicated. I am not being pernicky, but the fact that you might pick something up in the newspaper and follow it through indicates a lack of rigour in the system, if it has not come to you in any other way than a newspaper. In your response, can you say a bit more about the impression that I have got from the background reading—it is not compulsory for those people to tell you the information, or you do not enforce it or give a penalty if they do not? The theory is great, but what happens in practice?

Claire Foreman: I will pick up on four things. To answer your additional question—I am sure that we will come on to this in a bit more detail—we undertake horizon-scanning activity with a number of different stakeholders, particularly through our supplier engagement process. That plays an important role.

Specifically on your question about requirements and endorsement, it is a requirement on suppliers to report any shortages or discontinuations through the DaSH portal. Obviously, that leads to this question: should

we, therefore, always know that those things are coming? There is a requirement, but particular issues may mean that that is not always possible. I am sure that we will get into a bit more of that detail, and I am sure that David will want to follow up on that, but I thought that it would be helpful for me to add a couple of points.

NHS England's particular role in terms of medicines resilience and medicines supply relates to the secondary care medicines for which we co-ordinate national competitive tendering. They have terms and conditions that, equally, require suppliers to provide us with that information.

Two points related to that are, I think, worth noting. First, our requirement is now that suppliers have eight weeks of buffer stock; we not only ask them to tell us where there are issues around imminent supply disruptions but seek assurances from them that they have additional stock. Secondly, we are increasingly building on our methodology for value-based procurement, so we are giving a really strong signal to suppliers that we value resilience as well as value to the taxpayer. The way in which those value-based procurements work over time is to weight the criteria and scoring around some of those, so it is in a supplier's interest to make sure that it has met its terms and conditions and has supported and demonstrated its commitment around the buffer stock.

My final point here is on the importance of information sharing. We work very closely with the Specialist Pharmacy Service, which hosts the medicine supply tool; it is a sort of searchable tool that is available for clinicians so that they can find out information about supply issues. It provides an important interface to highlight some of those supply issues because, although we hope that the DaSH reporting requirement and contractual requirements will cover everything, inevitably, supply disruptions may well occur; we would much rather ensure that we have many avenues to hear about those so that we can pick up on them.

Q17 Lord Bradley: I have a quick question. As you have alluded to, you have identified lots of sources of information. Do you all have a common definition of what a shortage is?

David Simmons: Yes. Essentially, shortages have a common definition, and then they are all tiered in a system from one to four, tier 1 being the least serious, tier 4 being a serious risk to life and so on. Disruption from any source will be assessed and then put in one of those tiers.

To come back on the point about the media and so on, the DaSH portal is the primary source. From a manufacturer's perspective, they may say, "In aggregate in the country there is no supply issue that we are aware of", but in the media you can get localised pockets that we need to investigate because there might be something else going on in a local area.

On the cross-government stuff, if an international Government are proposing to put in place export restrictions on a particular product, the industry might not know that first. We might find that out first through posts working with our colleagues at Business and Trade. So DaSH is definitely the primary source but it helps us to have all those other sources underpinning it. We do not want to rely on just one source, because there are other angles to issues being identified.

The Chair: I want to check what you said about waiting for procurement. Is that now or is it a plan for the future?

Claire Foreman: We are undertaking those procurements now.

Q18 **The Chair:** I want to push you on one more thing before we move on to the next question. I can see that in theory your dashboard should cope with the supply end, but at the pharmacy end, since local availability could mean that a medicine could be available in the pharmacy down the road but not in the pharmacy where someone goes, how confident are you that your system for getting information about availability at the local level reaches you?

David Simmons: The legislative requirement is on the marketing authorisation holder, the supplier. In terms of the level of confidence, our visibility of exactly what is available in every single pharmacy across the country is far less than it is at other points of the supply chain. That said, we have close relationships with the representatives of the pharmacy groups. They feed intelligence to us, and we work with them to try to make improvements. However, I would certainly say that the statutory requirements and mechanisms for us to find out that localised shortage data is not as strong as it is with the suppliers and the DaSH portal.

Lord Mott: On that point, this may be a slightly naive question so I apologise for that in advance. On the question of visibility at pharmacy level, we are now in a world where my GP communicates with me via the NHS app on a fairly regular basis about a range of things. I am assuming from what you have said that you do not have any visibility across all the pharmacies across the UK. If you do not at this point, is there any imminent plan to be in a position with that dashboard, so that you could sit there today and say, "Across the whole of the UK we have very clear visibility of what is available and where there is a problem"?

Claire Foreman: It is correct to say that we do not have visibility of the stock position—which is what I think we are talking about here—in community pharmacies. There are probably a number of reasons for that. We have over 10,000 community pharmacies, many of which are independent, so these are not organisations that all use exactly the same systems. There are infrastructural challenges to imagining how we could get to a place where there was a comprehensive view across all community pharmacies. There may well be certain multiple pharmacies that are looking at mechanisms to do this. That would probably give some indication at their sites, but that would not guarantee to a patient that they could be absolutely assured on arrival that they could have that

medicine. In an ideal world, that would probably be great to have, but realistically how we could get there is a really important question.

So the things we have already touched on are important—that is, getting information from multiple sources about what we understand to be the position on supply; making sure that people are connecting to their SPS medicine supply tool so that everyone is up to date with what the supply position is on medicines; and making sure that people have information about what they should do if they experience some disruption in terms of the medicine. It does not matter what kind of medicine it is; if you turn up to your community pharmacy and your medicine is not there, that is very frustrating. Where we have particular shortages and community pharmacists are having to manage those, that is a burden on them. Some of the measures that we have talked about are ways in which we try to support in the absence of, effectively, a system that does not operate on one IT system.

David Simmons: To build on that, it is probably about the wholesalers. They are one step up because they deliver to the community pharmacies. We do not collect data from them on every single medicine but, where there are particular pressure points, or indeed over winter, we will work closely with the wholesalers, which are obviously much smaller in number and can give us a good sense of the regional picture. That is one step removed from the community pharmacies, but it is much closer to the local level than the manufacturers.

Q19 **Lord Carter of Coles:** I am a director of Icon, which compounds oncology drugs, and I am an adviser to Bain, which is quite active across the National Health Service in offering advice. I want to come back to the wholesaler question. What is the relationship between your aggregated data and the wholesalers? Do they report to you regularly? Does that go into the dashboard, or do you only pick it up through the secondary care reporting system?

David Simmons: This is one of the areas where, as I say, our relationships have become stronger over recent years. We have strong relationships with the trade association representing the wholesalers and the wholesalers themselves. We do not routinely collect data on the stock position of every product that they supply; we would do it more on a case-by-case basis. If there were to be a pressure point—a suspected shortage or something—we would work with the wholesalers to understand their stock position and so on. They are able to look both ways: at what is incoming to them and whether they can get what they are ordering, but also at whether they can fulfil the orders that they are getting. So we do not routinely collect data from them on their stock positions, but on specific items and indeed through the winter we work very closely with the wholesalers.

Lord Carter of Coles: Is it fair to say that you are always reactive and behind the curve? There is no automatic forecasting thing that constantly looks forward and says, “In three months’ time, there’s going to be a shortage because some plant’s blown up somewhere or something’s

happened”.

David Simmons: A lot of proactive work is done to look at the different risks that are coming down the track. Those could be regulatory risks or policies from other countries—various things that we would know about. There is a good process of horizon-scanning of those risks, and we particularly talk to the trade associations about them. I host a group with the major trade associations, and we look at sentiment: which threats are you and your members worried about in the next three to six months, and the 12 months beyond? We try to get a sense of that. So there is proactive work to try to identify both the industry sentiment on those risks and our chronic risks so we can try to prepare for them. As you say, though, there are some things that we are not able to predict, such as a factory blowing up in a particular part of the world, so we are simply in the reaction phase.

Q20 **Lord Shipley:** I want to ask you about the long-term sustainability and security of medicine supply. We have three witnesses, one from NHS England, another from the Department of Health and Social Care and a third from the Office for Life Sciences. The question is: where does responsibility sit within government for ensuring the long-term sustainability and security of medicine supply? Would the NHS like to start?

Claire Foreman: Actually, David might want to start, given that the department has overall responsibility.

Lord Shipley: I am very happy to hear from the DHSC.

David Simmons: Ultimately, medicine supply is the responsibility of the Secretary of State for the Department of Health and Social Care, and delegated to Minister Ahmed, who I think the committee is seeing next month. In terms of government responsibility, medicine supply is the Department of Health and Social Care’s core responsibility. Within that, there are a number of interconnections across government with trade policy, borders and lots of other things, so the architecture of the governance would be that if it is an emergency—

Sitting suspended.

Lord Shipley: My question has been half-answered; thank you for that. David, you have clarified one issue for me—that the question I asked should be answered first by the department, not the NHS. The question simply related to who is responsible for the long-term sustainability and security of medicine supply, as well as how you work together. You, David, talked about the interconnections between all of the people involved and the architecture that was being built. Can you expand a bit on what the architecture is and whether, in your view, there are gaps in it? Will what you have done or are doing actually be fit for purpose?

David Simmons: First, the architecture at ministerial level is that, if there is an emergency threat, it will come through the COBRA channels, which I am sure you are all aware of. National Security Council

(Resilience), a sub-Cabinet committee, is the cross-cutting resilience forum for slightly longer-term issues; things that relate to medicines will go, and have gone, to that group. So, in terms of ministerial accountability, it is the Secretary of State, but those are the two main accountability functions within that.

Underneath that official level, we work closely together. There are various meetings that we can go into that are set up within the "health family", if I can describe us as that. There is also infrastructure across government. DBT has a global supply chains programme, which regularly brings together all those who are responsible for supply chains across government. I meet regularly under that architecture with people responsible for food, defence, aerospace and so on, because there are many issues that are common to those areas. That is part of the answer, but you may wish to follow up and my colleagues may wish to come in.

Lord Shipley: I would like to know whether the NHS is happy with the role it is playing, given that there is a clear leadership role here for the department.

Claire Foreman: As David said, we work really closely together. That is important because I have described for you some of the specific responsibilities that NHS England has in relation to secondary care medicines. Although we own some of that architecture, to use that word, as David was saying, there are some important crossover points around, for example, how we work with suppliers.

To add to David's point, in recognising the end-to-end nature of supply chains, it is important to be clear about the expectations that we have of everybody who plays a role in a supply chain. We have touched on some of the expectations that we have around suppliers and information sharing, and we have touched on wholesalers and pre-wholesalers. There is a role here for regulators and for the NHS.

I would add that, in addition to the secondary care medicines responsibility, we must make sure that we are supporting prescribers and community pharmacy to make sure that they understand their roles around the resilience piece and how they can be supported. It is also about how we make sure that we link in clinical advice to the processes we undertake because it is critical that the NHS can bring to the table the issues of impact and the potential scale of supply issues that we have, thereby not only supporting the things that we should really be focusing on and the areas where we might have most concerns but, when we are in mitigation mode, having clinical advice in the process as well.

Q21 Lord Shipley: I turn to Andrew Howard from the Office for Life Sciences. In their written submission to the committee, the department and NHS England say there were 125 fewer life science manufacturing sites in the UK in 2021-22 compared with 10 years previously. Are you happy with that situation in terms of security and sustainability? Are you happy, on behalf of the Office for Life Sciences, with the structures that are set up to guarantee sustainability of supply?

Andrew Howard: Will it help if I explain briefly what the Office for Life Sciences is? I was not sure if everyone would know. We are a joint policy unit between the Department for Science, Innovation and Technology, the Department of Health and Social Care and the Department for Business and Trade. We were responsible, for example, for drafting the *Life Sciences Sector Plan*. In thinking about supply resilience and manufacturing, we are probably a level up from where David and Claire might answer some of the questions.

On medicines manufacturing, you are quite right: medicines manufacturing as a proportion of the life sciences sector has not grown in the last 10 to 20 years in the same way that the rest of the sector has grown. Your expert witness last week, Dr Fady, explained the challenges around the UK being competitive internationally for the commercial manufacture of certain products—small molecule products, basically. There have been a number of quite significant closures of manufacturing sites in the UK: Pfizer in Sandwich recently, Novartis—there have been a few.

On the other hand, the UK has real expertise in certain quite specific and innovative areas of medicines manufacturing. For example, there is a cluster in Stevenage in cell and gene manufacturing that was encouraged through government investment in the cell and gene therapy catapult. You may have heard recently about Moderna's manufacturing site in Harwell that was recently opened to manufacture mRNA vaccines. So, while it is correct to say that manufacturing has not grown in the way that we would have liked it to over the last few years, we have significant expertise in some important areas in the future for medicines, therapeutics and vaccines.

Lord Shipley: So are you content with the structures that are currently being used to assess security and sustainability of supply?

Andrew Howard: We could do more, and we always strive to do more. It is quite challenging because a lot of the information is held by commercial entities—companies—but we do a good job to try to co-ordinate across government and across industry to understand. It is an evolving picture, basically.

Q22 **Lord Prentis of Leeds:** I want to return to the dashboard idea that was put forward at the beginning. It occurs to me that the voluntary nature of the collection of information, which is vital to understanding where shortages are and what we need to do about them—mention was also made of pharmacies themselves having different definitions of what shortages are—is not necessarily the best way of collecting the information that you require. Is there a reason why we have not gone to more formalised arrangements where there is a requirement to notify?

David Simmons: In the legislation there is a mandatory requirement for marketing authorisation holders—the suppliers—to report to us. That system has not been in place long; it was introduced a few years ago, and I think we are seeing stronger adherence to it. On the whole there is

good reporting to us through those routes, but would I sit here and say that 100% of all shortages that are identified are shared with us in the timely fashion that we demand? Probably not. We are looking at the information regulations in terms of how that can be strengthened and how we can use the powers to enforce that.

There is a principle of proportionality. We are seeking to win a trusted relationship when it comes to why we need the information and what we do with it. That information, where it is shared, is commercially sensitive, so we have to show that it will be treated correctly, since the best way is for the suppliers to report to us because they want to and think it is helpful, and the vast majority of them do so.

As I say, we are looking at the information powers, but there will be proportionality to that, because if someone is having a struggle with a shortage then hitting them with a penalty may not always be the best thing to do. We are looking at that to try to drive further improvement in it. It is a mandatory requirement, and I would say that on the whole it works pretty well, but we would like it to be better. Finding out about disruptions early is critical, so we are looking at the best ways to do that both through soft channels and where it might be appropriate for us to use slightly harder tools.

Q23 Lord Mott: I have a question about accountability. If there were a serious failure, ultimately which Government Minister would be stood at the Dispatch Box in the House of Commons? You mentioned different departments, and I understand that that happens, but ultimately which Secretary of State would have to go to the House of Commons and make the Statement?

David Simmons: On medicine supply specifically?

Lord Mott: On a serious supply chain failure.

David Simmons: If the topic was medicines, it would be the Secretary of State for Health and Social Care. Sometimes the issues are broader in nature and affect lots of different supply chains across the economy, so that would probably fall to a business or trade Minister, but if it is about medicine supply it will be the Secretary of State for Health.

Q24 Lord Carter of Coles: You are probably in a hot spot, are you not? Given global tensions, the possibility of ships going down in the Red Sea and tariffs being imposed, the whole world pharma market is in a state of high drama. My question is about resilience and price and how the Government intend to balance those. We talked about getting data from the manufacturers and so on. My sense is that that seems a bit woolly. Am I correct in assuming that other countries use extensive barcode systems on all pharmaceuticals to deal with—I think you mentioned the phrase “end to end”—the end-to-end question, particularly regarding things like rip-off drugs? Is there any thought from the department that we are going to build a much more resilient supply chain monitoring system, or are we going to continue with this rather more informal way of

doing it?

David Simmons: There are quite a few issues in that question. In the geopolitics of recent years, the risk level has heightened. There are many topics that I did not think I would be talking about; in the first few years, topics like global conflicts and the onset of tariffs were just not discussed, though unfortunately they are discussed substantially now. So there is heightened pressure from those elements, and they provide challenges in lots of different ways. One of those is the commercial viability of products and indeed companies. There is a lot of proactive work to look at chronic risks and our preparedness; to look at where we are vulnerable to them; and to do exercises, et cetera, to test our ability to mitigate the impacts. The DaSH portal gives us the root causes of disruptions. The most commonly cited cause is manufacturing—often, the availability of raw materials, active pharmaceutical ingredients and so on.

The second most common cause—around two cases in 10—relates to consumer demand, where there is a big spike in demand for a specific product that either was not predicted at all or whose scale was not predicted. Then about one in 10 cases are caused by regulatory failures, non-compliance and so on in that space. Regarding the data that we have, a lot of external pressures impose additional stress on the system, but price does not regularly come through as a specific reason for a shortage in the way that it is reported to us. Obviously, there are clear economics within that.

Lord Carter of Coles: To be clear, are you confident that your existing data collection—it is a data issue that I am pursuing—is sufficiently robust and timely to let you identify problems that are coming? They are going to change all the time. Who knows? It could be anything. How confident are you that the system you are using to oversee this supply chain is robust?

David Simmons: I do not think I could ever say that it is entirely robust because, as you say, the goalposts keep moving all the time. For longer-term, more chronic risks, we would use as a basis the national risk register, which has 89 risks—reasonable worst-case scenarios—in it. We look at those 89 risks and identify which ones are relevant to or pose a threat to medical products. For those ones, we then look at how prepared we are. If that were to happen, how vulnerable would we be? Would it impact just a subset of medical products, or would it be across the board? We might do exercises to gameplay what we would do in those scenarios, which may involve parties across government or industry.

Lord Carter of Coles: Are you really confident that it is okay? That is all I want to know, because we are a bit tight for time.

David Simmons: It is good, but we should always try to do better.

Lord Carter of Coles: That is a classic answer; forgive me, but we would all say that. Does the department feel that it has the structure in place, given all the vagaries?

David Simmons: Yes. We always want more, but yes.

Lord Carter of Coles: Fine; that is all I wanted to know. Moving on, you mentioned the risk register. Presumably, this is on the department's risk register.

David Simmons: Correct.

Lord Carter of Coles: How is it ranked on the risk register?

David Simmons: It is ranked relatively highly. I do not have access to where it ranks alongside the other risks that are on there. That goes into the—

Lord Carter of Coles: They normally have a colour, do they not?

The Chair: You mean its status?

Lord Carter of Coles: Yes. Could you perhaps write to us and tell us what it is?

David Simmons: Yes.

Q25 **Lord Carter of Coles:** That would be helpful. My last question is about stockpiling. Given the state of the world at the moment, we have noticed that other countries, such as Germany and the United States, are stockpiling, particularly APIs. What is the department's view on that? Should we be doing it?

David Simmons: We stockpile for specific cases. There are specific stockpiles for pandemic preparedness, which include medicines. We have recently extended an IV fluids stockpile as well, specific to medicines.

It is also true that we have sought to move away from stockpiling as the primary mitigation that we may have had in the past. From 2010 onwards, there was the emergency medicines buffer stock. In Brexit, we asked the industry to build a six-week stockpile, and so on. Our approach is to have a multilayered approach; stockpiles can play a role in that. As I say, the department has a set of stockpiles, mostly focused on pandemic preparedness, but we want a more robust set of varied tools because diversification of the supply chain is critical. If there is a problem in one area but there are other manufacturers in other parts of the world to which we can easily switch, we see that as a more resilient approach than having a stockpile, which could potentially be burned through quickly while you have not solved the root cause. We are seeking to impose a multilayered approach where stockpiling has its place but is not the sole element.

There are many different ways of doing stockpiles. We are very aware of what other countries are doing. There are government-held or government-owned stockpiles, all the way to manufacturer-owned or manufacturer-held stockpiles. They are costly. You cannot stockpile everything—radiopharmaceuticals are a classic example of something you cannot stockpile—and they can exacerbate shortages. What we see in

many shortage scenarios is that stock must be moved quickly across borders, often by companies themselves, from one market to another in order to put patients first.

Lord Carter of Coles: This committee finds it rather odd, I think, that the Germans and the Americans apparently take a different view. To Lord Mott's point, it would be interesting to hear the Secretary of State go down to the Commons and explain why we did not stockpile. I am not quite sure about your multilayered approach, with bits here and bits there. If a critical API coming out of China stops, it stops. The countries that have stockpiled get time to adjust, at least, but the fundamentals of the APIs are not getting to the manufacturers. Anyway, that is the department's response; as long as we have recorded that, that is fine.

The Chair: I want to be clear about the EU bit, which has been touched on. We left the EU, so we left a partnership that was taking action, though I cannot quite recall whether it was action to stockpile. I read that we were going to set up our own system but have not done so. Have we decided not to set up our own system, or have we just not got round to it?

David Simmons: Just to clarify, on stockpiling or on the falsified medicines element?

The Chair: Falsified medicines. Sorry—I am probably conflating two issues now.

David Simmons: No; that is totally fine. As you correctly say, we have left the EU. We have the powers to introduce a similar system to the EU's on safety measures and so on. The MHRA is active in doing its assessments and inspections, and we are quite confident in that system. I would also note that there are examples of where the EU system has not picked up certain examples of where falsified medicines have made it on to the market. Still, it is something that we are actively looking at in terms the right thing for the UK to do in introducing something similar or something slightly different. It is an active discussion with Ministers at the moment.

The Chair: It is just a very long time since we left the EU.

Q26 **Lord Laming:** Resilience is a multilayered aspiration. Can any of the three of you, or all of you, say, first, whether you monitor waste? Secondly, can you give us some idea of how you handle waste?

David Simmons: I am not aware of the department specifically monitoring waste. Where we stockpile, we try to ensure that nothing comes out of date and therefore becomes waste and needs to be disposed of, but, out in the system, I am not aware of the department holding data on waste. Claire might know.

Claire Foreman: Medicines waste is something about which prescribers in particular are concerned. It is very much part of medicines optimisation. The answer on whether that is tracked is that that is hard to

do. There are many scenarios where medicines waste may occur, but we know that there have been lots of more narrative reports—for example, when clinicians or healthcare professionals go and visit someone in their home, and they open cupboards to find lots of packets of medicines unused.

My observation is that this is where things such as the medicines optimisation approaches really come into their own. I have seen a number of different examples. These tend to be localised because they are very much about the prescriber's engagement with patients. There are a few examples of where integrated care boards and their local prescribing community have run local campaigns about ensuring that patients order only the medicines they actually need—particularly patients who have repeat prescriptions. This is an important activity that people can undertake to reduce waste. The pharmacy profession itself—if you had David Webb here, he would certainly be talking about this—says that this is something that not only prescribers but pharmacists take very seriously.

Lord Laming: I have one more question about that. It strikes me that, through hospitals and pharmacies, the range and volume of medicines must vary enormously. When we talk about resilience, it is not all about purchasing; it is also about monitoring. I take from your answer that there is no monitoring control in the National Health Service of waste.

Claire Foreman: I want to clarify that. As David has indicated, the department does not track that, and it probably is true that we do not have a central national mechanism for doing that. However, I am confident that at hospital level, and certainly at ICB level, waste as part of medicines optimisation approaches is something that people will be monitoring closely. I am confident that it is looked at locally, but it is not something that we track at a national level.

Lord Laming: I hope you are right. Let us travel hopefully.

Q27 **Baroness Cass:** I want to ask Claire about this because I am wondering if there has been a change in national strategy. I have a repeat prescription, and it worked seamlessly for years. I used to order it on the NHS app a week before I ran out and then the new ones would be there, but suddenly there seems to have been a change to automatic dispensing and now the meds arrive at random times or, most recently, not at all. At one point I had twice as much supply as I should have done, but then last time they said it had all been stopped even though it is something that I have been on for years. Is this part of a national strategy change to automatic dispensing or just something random in my practice?

Claire Foreman: I am not familiar with exactly what you have described there, but I am someone who has repeat prescriptions as well, so the description that you gave is one that I recognise. The policy would work in a way to ensure that patients are not over-requesting their medicine, so there is a mechanism for making sure that we understand when prescriptions would be expected. I am not aware of the change that you

have described there, but I am certainly happy to take it away and ensure that if there is any further information that the committee needs on that, I can provide it.

Baroness Cass: That would be helpful. Perhaps it is just a local quirk but, as I say, it has gone from a seamless system to a non-functioning one.

Q28 **Lord Mott:** I want to pick up the theme of manufacturing. My question is in two parts. First, is there a way that we could recycle the waste or the unused medicines in this country? We had some evidence last week, but it would be good to get your view on that and whether, through the Office for Life Sciences, we should be encouraging companies to look into that and see if we can pick up some of those medicines that are not being used and use them or parts of them again. Secondly, on manufacturing, if the Government could focus on certain medicines that this country should get behind in terms of manufacture, what in your view would they be?

Andrew Howard: On your first question, I would not say that it was in the remit of the Office for Life Sciences to encourage companies on waste. Something that is important to think about is that the majority of medicines used by the NHS come from abroad while the majority of medicines manufactured in the UK are exported. That is because a lot of what we manufacture here is high-value innovative medicines that require a lot of expertise and skill.

On the waste point, I leave that to my colleagues. Specific medicines are also probably for my colleagues, but I will say—and your witness last week, Dr Fady, mentioned this—that we in the Office for Life Sciences are concerned about the onshoring of manufacturing and trying to incentivise investment in UK manufacturing. A key lever that we have to do that is through our life sciences innovative manufacturing fund, which has two objectives: driving health resilience for the UK, both in peacetime and in pandemic, and economic benefits. When we make a health resilience assessment of an applicant to the fund, we think about the type of product that they might make and whether it is on a critical medicines list or on a shortage list. Is it the type of product that would be useful in a pandemic or is it something that is critical for the NHS? We also use an expert panel of industry experts to consider the capabilities of the manufacturing site. Is it flexible? Is it pivotable? Could it scale up manufacturing in an emergency or switch to a different product? Those are the types of things that we think about.

We have been quite successful in encouraging investment in manufacturing over the last few years through predecessor schemes. In fact, we announced our first grant winner from the new scheme of up to £520 million, which is a generics manufacturer in Birmingham, an SME. To answer the question about trying to encourage manufacturing in the UK, that is an investment in a company that is manufacturing generic medicines in Birmingham, and we hope to be able to encourage more

investments. At scheme level, within the OLS we probably tend to be less product-focused and more investment-focused. I hope that helps.

Claire Foreman: Shall I pick up on the reuse question? Obviously medicines are highly regulated in terms of both how they are prescribed and how they are dispensed. For both those reasons, the reuse of medicines in the way that your question suggests is quite limited. The regulation set out by the MHRA is intended to promote patient safety and ensure that patients get the medicines that are appropriate for them, and that those medicines come to them in a way where we can all be assured that they have been stored in an appropriate way. If you have a scenario where there are medicines that have already been dispensed but not used, that raises particular questions about giving surety around quality and safety for the patients who might then receive them.

However, that is not to say that it is not possible. In Covid, a particular set of arrangements was agreed with the MHRA that allowed some of that reuse to happen for a particular set of medicines in a particular scenario. Within hospital pharmacies, where they are more in control of what is happening in the moment with the medicines, some of that reuse is possible, but in general it is one of the trade-offs around the regulatory nature of ensuring the safety of medicines as they reach patients.

Lord Mott: That is really useful. Do you feel as if we are almost gold-plating the regulation around that? During Covid, when things were a bit more agile and people were prepared to be more innovative, we perhaps did things. We still had the right sign-off but we were prepared to go that little bit further. Then in peacetime, for want of a better description, we just drift back into the systems that we are familiar with. If there was perhaps a little bit of work done on this, that could open up quite an interesting avenue for the Government.

Claire Foreman: The fact that it is possible in certain circumstances shows that in principle there are scenarios where the threshold for safety can be met. However, a lot of archotyping would probably be required to be precise about which scenarios, which patients and which medicines. There are administrative processes that need to sit underneath how you would reuse medicines in a safe way, so those would need to be taken into account as well.

Q29 **Lord Laming:** It is said that a high proportion of patients feel disappointed if, when they visit a GP, they do not leave with a prescription. I was really surprised—this is my ignorance showing; you will have to forgive that—to hear on the radio this morning that between 8 million and 9 million people in this country are taking antidepressant medication. Is there any active monitoring, influencing or controlling of the way in which medicines are used or is it, frankly, a free-for-all?

The Chair: The unregulated bit of the system?

Lord Laming: Yes.

Claire Foreman: I am smiling because I was not surprised to hear that people quite often go to the GP and expect a prescription; that is interesting. I heard the report on the news this morning. We have touched on the regulation of medicines already. Clearly, prescribers are also highly regulated in terms of their prescribing activity and their fitness to practice. Information is available to guide prescribers about the appropriate medicines that they should use, from the British National Formulary, which gives people information, through to NICE guidance on specific medicines or NICE guidelines on the best approach to particular treatments.

I have two other points. Antidepressant usage is something about which people in the medicines optimisation community are very concerned. There is close monitoring of that and a real focus on both how prescribers can be supported and how local health systems can make sure that there are wider options, beyond prescribing medicines, for patients who may have depression or other forms of mental health support requirements.

To link this to the single national formulary announcement in the 10-year plan—it is almost a recognition that we have all of these arrangements in place to try to ensure that there is consistent safe prescribing of medicines; we want see more of that—in the next two years, we will be moving towards a single national formulary. That is intended to make sure that there is consistency and standardisation in how medicines are prescribed and used.

Andrew Howard: Can I make a quick observation about antidepressant medicines? I am by no means an expert, but did the story imply that all of those prescriptions were for depression? In my experience, you can be prescribed antidepressant medicines in small doses for nerve pain.

The Chair: It was not that specific, was it?

Lord Laming: What?

The Chair: Apparently, you can be prescribed antidepressants for things other than depression.

Lord Laming: Oh, okay.

Andrew Howard: It is a common thing to prescribe for nerve pain.

Lord Laming: Thank you. As I say, forgive my ignorance.

Baroness Cass: That is a good point about prescription for nerve pain but, if you asked for my gut feeling, I would say that that is probably a small minority of the prescribing. Probably the more common prescription for nerve pain now is something called gabapentin, which is also used for convulsions as an anti-epileptic drug. I suspect that the bulk of these prescriptions are actually as an antidepressant.

I was going to say that a big problem, in addition to initial prescription, as we have discussed before, is the lack of review of patients who are on

meds over a long time or on a cocktail of medications—that is, reviewing them and taking them off. It is a reflection of the pressures on primary care that doing those plan things is probably much more difficult and falls off the pile more easily than responding to the influx of urgency.

- Q30 **The Chair:** There were some nods from our panel at that. My apologies if I just did not pick this up when we were talking about nearshoring and onshoring, but you talked about what the United Kingdom was doing. Can you say a bit about whether we are making partnerships with small groups of countries in order to give us extra capacity in that way, so that we do not go it alone but we have reliable partners, splitting the process between them or whatever? Do we do that?

Andrew Howard: Again, apologies, but that is slightly outside of my remit. Our focus in the Office for Life Sciences is on working with companies to encourage them to make investments for their own commercial use in the UK. I believe that there are, say, philanthropic partnerships to encourage vaccine manufacturing and development.

The Chair: But there is no one in charge of doing that for the country.

Andrew Howard: David might want to come in and support me.

David Simmons: We cannot domestically onshore every single medicine; there are 14,000 medicines. For me, nearshoring reduces the risk considerably versus concentrating it in certain places. Friendshoring forms part of the regular discussions that we have internationally with lots of different countries to observe what they are doing, how it is compatible with us and whether we can benefit from it, either informally or formally.

Last year, the DHSC joined the EU's Critical Medicines Alliance, thus making sure that we are part of conversations on what will happen in the EU in terms of domestic manufacturing there, in order to see how we can benefit from those elements. If that increases the diversity of manufacturing capability across the world and allows us to buy from more different places, we would see it as a good thing. That is something we are very aware of and are seeking to do.

The Chair: Okay. It does not sound as if we have made that much progress.

- Q31 **Lord Carter of Coles:** Coming back to Lord Mott's point, is there any policy in the Government or the department to pay more for medicines in order to ensure resilience? You mentioned the investment that has just been made; that was a deliberate attempt to attract investment into the UK to produce, as I think you said, generics. Could it be part of that policy? I do not understand how we can become resilient for some small percentage of medicines unless there is an incentive, because it will always be cheaper to manufacture them in low-cost countries. Is any consideration being given to that?

David Simmons: On domestic manufacturing, resilience is a key component of the assessment. I am always badgering Andrew to make the best use of that money to help resilience; it is balanced across the economic objectives. There are things in that sense.

On procurement, the new procurement rules that have been coming in and continue to come in also seek to make resilience a key criterion of those tenders. Claire may wish to expand on that.

Claire Foreman: Exactly. Suppliers will have felt in the past that a tender's primary criterion was price. The move to value-based procurement is about recognising that value remains important but so does supply resilience. The weighting will reflect that in a supplier's track record of what they are doing around supply. Tenders are driven in a way where it is down to suppliers to say what price they want to put in a tender. We have a framework where suppliers know, because we have signalled to them that we value these things, that they will submit their tender prices and those tenders will be assessed and evaluated in accordance with those criteria. Over time, that basically reconfirms that all involved are putting value on that resilience, but it comes back to the diversification point that David made previously: this enables us to broaden our supplier base.

Lord Carter of Coles: That is good news. When you have a tender, is there a specific box that you have to fill in on resilience? If so, what is its weighting in the tender?

Claire Foreman: Yes. There are quite a lot of criteria, although I do not have all the technical details.

Lord Carter of Coles: I do not want the detail—just the principle. Is it there in the scoring?

Claire Foreman: Yes.

Q32 **The Chair:** We have some back-to-back votes coming up. I am keen not to have you sitting here waiting for 15 minutes, so we will finish soon. We have two or three questions about what you have said. If I put them on the table now, could you write to us about them?

The first question goes back to Claire's point about shortages. You talked about the tiering in shortages but I am not sure that we ever got the definition of "shortage"; it may be that we did not quite grasp that. How frequently do you think shortages occur? Do you have a definition that goes right across the sector? How many times do we get a shortage?

Secondly, we know that you have the power to fine people for not reporting shortages. How often have you done that?

David Simmons: To my knowledge, we have not.

The Chair: We will take that as your answer but, if you find that it is other than that, please let us know. We would have followed up on that

had we had more time.

We have about a minute left. Does anybody have any last questions? We will offer our thanks properly, then. We are really sorry that you have been disrupted in this way. I understand that it spoils the flow of the conversation and means that you have been here longer than you might otherwise have been. We are very grateful for the help that you have given our team. We hope that we will be able to come back to you in writing during the course of our inquiry about anything that we have not managed to take up now. I declare the meeting closed.