



Public Services Committee

Uncorrected oral evidence: Medicines security

Wednesday 5 November 2025

11 am

Watch the meeting

Members present: Baroness Morris of Yardley (The Chair); Lord Blencathra; Lord Bradley; Lord Carter of Coles; Baroness Coffey; Lord Laming; Lord Mott; Baroness Pidgeon; Lord Shipley; Baroness Wyld.

Evidence Session No. 3

Heard in Public

Questions 33 - 44

Witnesses

I: Malcolm Harrison, Chief Executive, Company Chemists' Association; Martin Sawyer, Healthcare Distribution Association; James Davies, Director of Research and Insights, Community Pharmacy England.

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Examination of witnesses

Malcolm Harrison, Martin Sawer and James Davies.

Q33 **The Chair:** Welcome to this meeting of the Public Services Committee and to our inquiry into medicine security. I welcome our witnesses today and just ask them to introduce themselves.

Martin Sawer: I am executive director of the Healthcare Distribution Association. We represent those wholesale distributors in the middle of the supply chain who buy medicines off the manufacturers and distribute them to all the pharmacies, hospitals and doctors.

Malcolm Harrison: I am chief executive of the Company Chemists' Association. We are a trade body that represents multiple pharmacies across England, Scotland and Wales, and between them, all members operate around 4,000 pharmacies.

James Davies: I am the director of research and insight at Community Pharmacy England, an organisation that represents the owners of all 10,400 pharmacies across England.

The Chair: You are all very welcome. Lord Bradley, do you want to start us off?

Q34 **Lord Bradley:** Thank you, Chair. How resilient do you think each of the supply chains are?

Martin Sawer: Representing the UK's medicine supply chain, our members distribute to all four countries with no notion of geographical boundaries. We distribute 95% of NHS medicines to every single pharmacy, hospital and doctor across the UK, twice a day, on average; that is 16,000 outlets. It is a massive, intensive logistical exercise employing about 10,000 or 11,000 people directly.

I would say that the supply chain as a logistical exercise is very resilient. In the UK, the supply chain and the delivery mechanisms are very good, and they are driven by incentives.

I am pleased this inquiry is being conducted because we are concerned that some of those incentives are driving behaviours that, perhaps, make that supply chain more fragile for the future than it has ever been.

Secondly—and I know this is a remit of the committee but it is outside my remit—an understanding of medicine security for the UK, globally, is also of concern, given that the supply side of medicines is driven by global concentration of global businesses, in fewer places than used to be the case.

On the demand side, as I mentioned, it is becoming very complicated. There are lots of technologies in primary care, whether you have hub-and-spoke distance-selling pharmacy or online pharmacy. The outlets that we supply to have varying demands that are difficult to understand and see. So medicines could well be in the wrong place, which I know is

part of your inquiry. We have concerns about how that might manifest itself in, say, 10 years' time, longer term.

My pharmacy colleagues will talk about the parlous state of community pharmacy. The economic drivers for us are key in this. Private sector businesses have always done the NHS distribution since 1948 and before. They operate on very low margins, and the efficiencies are unbelievable.

The prices that we, or the NHS, pay for medicines are the envy of lots of countries: 800 million packs a year cost 99 pence or less to the NHS. That pays for everything from the creation of the API all the way through to the patient.

So it is an incredibly efficient system, which other countries envy, but you could perhaps say it is being pared to the bone a bit. Although we deliver well into the high 90s on all our orders, if any patient cannot get a medicine, then that is not right.

We all recognise that in the supply chain. People stay in the supply chain at all different levels, because that is what they want to do: get medicines to patients.

The fragility at the moment, I would suggest, is probably driven more by economics and technologies, as well as, perhaps, by lack of communication within the supply chain and some lack of accountability by some players in the supply chain to the authorities.

Overall, I think the system is very good. It is about tuning the engine, if we can use that analogy, which has probably not got enough petrol in it to flow properly and balance demand and supply, which is what our business does.

Malcolm Harrison: It is a relative question, with a relative answer. Of the 14,000 licensed medicines in the UK, the vast majority are in good supply and are able to get to patients, but the times when they do not get there are what we are concerned about.

I share Martin's concern that the number of times we are not able to supply is increasing. The evidence shows that resilience is being eroded in the supply chain. That is why we are here today: to explore why we think we are seeing these fragilities—these cracks—appearing, why we think they are becoming more frequent, or getting worse than they were, and what the solutions are.

I would echo Martin's views that there are many reasons for any shortages that we find. There is a large percentage in the supply, or the manufacturing, sides of things, where there is an economic reality about how we ensure that the market through which medicines flow is competitive and viable. That is something that we are very keen to explore today.

James Davies: I agree about economic fragility. The resilience of community pharmacy is the final point that many patients encounter with

accessing their medicines; it is a key part of that supply chain. As pharmacy continues to be underfunded—the NHS’s own commissioned research shows that there is about a £2 billion funding deficit for community pharmacy—we are seeing that pharmacies are closing, and that the resilience that exists within the community pharmacy network is decreasing.

To use the analogy of the engine, we are certainly reducing the oil in some parts of that engine, and it is starting to seize up in places. That is impacting patients. The most recent research that we have from the Office for National Statistics—its research data on health insights—suggests that around one in five patients is now having a problem with accessing their prescription medicine immediately in a community pharmacy. In many cases, those patients are having their problems resolved on the same day, by the next day or very soon afterwards, but it is certainly having more of an impact on patients than it ever has before.

Lord Bradley: I think that we can move on because we will pick up on some of those fragilities in our other questions; I do not want to hog them in the first question.

Q35 Lord Mott: I want to centre this question to start with Martin but, before I get to it, I would like to explore the accountability point that you made in response to my colleague. My main question is: do pharmacies and distributors have access to the information that they need to manage medicine stocks and shortages appropriately?

Martin Sawyer: Can I just try to understand what you mean? Do wholesalers and distributors ever access—

Lord Mott: Do they have access to the information that they need to manage medicine stocks and shortages appropriately?

Martin Sawyer: The wholesale distribution sector works very closely with the manufacturing partners to try to understand the forecasting that manufacturers have worked on for UK distribution. That can be really top-class, with some of the well-known global companies doing almost weekly stocktakes with their wholesaler and trying to understand exactly where their products are going, or there could be no contact at all. There is everything in between; there is huge variety.

The manufacturer is the first port of call for ongoing stock understanding by the wholesaler. Of course, the trouble is that the manufacturer may supply more than one wholesaler, and wholesalers cannot talk to each other because of competition reasons: they are all trying to get the manufacturer’s business. So there is a challenge around visibility there—but the manufacturer knows that, so, obviously, it will direct its products accordingly and share stock levels as appropriate.

If there are problems, such as a stress time, the Department of Health will get involved because, by law, the manufacturer has to report any stock problems for the UK, as you know. The Department of Health will then take a view because it has a medicine supply team, with which we

work closely. It is a terrific organisation. We commend the paper that it did in the summer—I know that the committee has looked at it—on managing the resilient supply of medicines, because that really explains a lot. Its systems are very good, and we have very good, open dialogue with it.

It will take a view as to whether the manufacturer's problem is serious enough to involve other players in the supply chain; it can do that. It can involve the wholesalers, either individually or as a group—including some of my members—to decide whether we need to manage that stock because it is not enough for the UK.

It goes right down to EpiPen a few years ago. That was a real crisis—literally. The DoH was managing that prescription by prescription through the wholesaler, which could supply one only when the patient needed it because there were so few. That was obviously a really critical situation. There is a 24/7 open line to the Department of Health and the manufacturer so that that combination can work in crises, as it did with HRT and ADHD to an extent. Obviously the patients still did not get their medicines, but we had to manage that crisis.

So, in answer to your question, we get visibility when there is a crisis but we do not get it in normal times, other than through the individual manufacturer-wholesaler commercial relationship.

Malcolm Harrison: From a community pharmacy point of view, each business will understand its forecasts of use and need for each medicine; they will make sure that they have in supply enough to meet the needs of their patients over a period of time, based on how frequently they can get those deliveries in.

Community pharmacies will not have sight of shortages coming down the line. The first they will probably know about it is when they turn to their wholesaler and say, "I need X", and the wholesaler says, "No, that's not available", or, "We're going to have to limit how much we give you because of other things that are going on". That system works because, often, the wholesalers will want to supply whatever they can, but, if the supply is limited, they will need to ration it out; as Martin explained very well, that is done with the department and so on.

One point I want to make, though, is that pharmacy businesses are now struggling to hold sufficient stock to meet the needs of their immediate forecasts of patient needs. Perhaps there was a time when they would be able to hold some stock just in case somebody needed it, whereas, as margins have been squeezed—we have talked already about the community pharmacy contractual framework—the gap between the cost of providing NHS pharmaceutical care and what people currently pay means that businesses are having to make some very difficult decisions. They are having to ask themselves, "Can I keep a couple of boxes of that in stock, just in case someone comes in, or do I have to wait until someone comes in then try to get it, with the risk that it might not be available?"

So we are starting to see a change in the behaviour on the community pharmacy side. It used to be that you would keep something just in case because you were in competition with other pharmacies and you wanted to make sure that you retained the custom of those patients. Now, more and more pharmacies are looking at cash flow and asking, "Can I afford to tie up the little cash flow that I have in stock that sits on the shelf just in case, or am I better off just waiting and assuming that I will be able to get it just in time?"

James Davies: That is certainly the case. Part of your question was about that information flow coming down and through to pharmacies. When we think about the definitions, the Department of Health spent a lot of time focusing on whether there is enough of a medication within the UK's shores, but, actually, patients often experience supply disruptions rather than supply shortages. It may be that you have not kept the extra couple of boxes on the shelf, so the patient does not have access to it.

We also see lots of cases where someone is in a particular geographic location and demand or prescribing behaviours have changed in that area—particularly for things such as branded generics, which cause a lot of problems—so a sudden increase in demand in the region has led to a shortage. As a pharmacist placing an order with my wholesaler, I often get a message that says, "The manufacturer cannot supply"; it is called an MCS. However, very often, I might not necessarily know whether that means the medicine will be back in the next day, the next week or the next month; that is because the information has not flowed from the manufacturers all the way through the supply chain.

Information about serious supply shortages is provided by the department through the SPS medicine supply tool, but that information is often lagged to the immediate order that I get in the pharmacy, so I have to say, "I can't get hold of that product". Sometimes, the information coming through from the department even arrives a month or two later, by which time I have already had to deal with many patients coming through—patients to whom I have had to prescribe alternatives or with whom I have had to try to do different things.

Q36 **Lord Mott:** My follow-up question is: would introducing a digitised supply chain in the management process, through something such as the falsified medicines directive, improve the information that is available about medicine stocks? What might the barriers or challenges to this be?

Martin Sawyer: I am happy to answer that question; I would like to split it in two.

Digitising the supply chain would help. Being able to understand each player in the supply chain would mean being able to understand where their stock was. I am not suggesting that we have an overarching tsar who has visibility of every pack going around the UK, because that would be costly and almost unmanageable. We did that—we supported NHS England in Covid like that—and it was a massive exercise for just hospital ICU products.

We would support the digitisation of the supply chain. At the moment, we are running some trials, with the MHRA and some of our members, on exactly that so that it would be a safer supply chain; that is because there is evidence of online falsified medicines getting into the UK, which we can talk about separately.

We also want manufacturers to continue putting 2D barcodes on their packs. Because of Brexit, they do not have to do it any more; the EU mandated that. We need them as some of our machines will not read other barcodes, including the 1D barcode. It is an option at the moment, but we would like to see that brought back as a recommendation.

We would suggest that FMD is not a stock capability system at all. All it has been able to do is maintain a level of patient safety. It puts packs on the database and you check them out at dispensing, but you have no knowledge of what goes on in between in the supply chain. Unfortunately, we have found in the UK some falsified Ozempic, which went through the FMD system in two European countries. It was incorrectly handled; it should have been decommissioned but it was not. It was a wholesaler in Birmingham who, just by looking at the pack—with his GDP, or good distribution practice, training—noticed that it did not look right. That stopped some vials of insulin inside Ozempic pens getting into the supply chain.

So FMD is not foolproof. If there is going to be a system, the UK needs to look at reducing this. It could look just at critical medicines or those on an MHRA watch-list—medicines about which it would be concerned—because that was the original intention of FMD, although it then covered all prescription medicines and so became unwieldy and very expensive. FMD is a patient safety operation; it does not really look at stock. Even the EMA has now decided that it cannot use it for shortages monitoring, because one pack can be on a database full-time so you do not get the right number of packs.

Malcolm Harrison: I agree that digitalisation will really help with transparency and understanding. We still have a paper-based system that has been digitalised, so there is an opportunity to look again at how we can incorporate the digital world in order to facilitate transparency around where stock is. I agree with Martin that the FMD is not the solution. Look across the channel: they have the FMD, and they still have shortages and still do not know where things are. So I do not think that it is an off-the-shelf system that you can use, but there is an opportunity to streamline and digitalise the current supply chains in the UK.

James Davies: I do not have a huge amount to add to that other than to support the recommendation for clear 2D barcoding across all products; that would make it a lot easier from a safety point of view.

Q37 **The Chair:** Let me ask another question, then, if you all agree. Why is it not happening? You are all sitting there saying that it is a great thing, but I cannot see how you could ever know whether or not there is a shortage unless it happens. It seems so necessary, so where is the blockage and

who should be taking the initiative to make sure that this happens?

James Davies: On some of the points that we have already made, many of the individual packs that are moving around the system are less than £1 in value. If you start adding big digitalised systems, with different barcodes and different ways of doing things, it starts to add cost to that system.

The Chair: Some bars of chocolate still cost less than £1 and they have a barcode.

Malcolm Harrison: A bar of chocolate does not last a month, though.

James Davies: Yes. The standardisation of that barcoding does not exist on all products, although it should. There is an approach with the MHRA to look at enforcing that regulation with the manufacturers.

Malcolm Harrison: It sits with the MHRA, in answer to your question.

The Chair: Are you optimistic?

Malcolm Harrison: We would like to see it. There is a demand and a push from this side of things.

The Chair: Yes, I can hear it.

Martin Sawyer: We already operate a digital system within wholesale if we can. The challenge is to get from the manufacturers a pack that can be read all the way through the supply chain. Some pharmacies also do not want to give out their paper invoice, on which they tick stuff off and send back. A lot of behavioural change is needed.

Lord Mott: You have answered on barcoding really well, so I am happy to let others have a go.

Q38 **Lord Shipley:** I thank you for your written submissions; you have all given us quite detailed submissions, which I have found particularly helpful. I would like to ask about the incentives and disincentives for pharmacists and medicine distributors to maintain a resilient supply chain. Mr Davies, I will start with you. How might medicine supply in primary care be better incentivised? What is wrong with the current model for funding? In your initial contribution, Mr Davies, you said that pharmacies are seriously underfunded. How does that funding model impact on resilience of supply, and what do you think should be done to put that right?

James Davies: Pharmacies play a fundamental role in helping to support the supply of medicines. With the way the system works at the moment, pharmacies are incentivised to procure medicines based on price, so we are not looking at value. We are not doing value-based procurement, as we see in secondary care, and we are not looking at resilience; it is about the lowest-priced medicine that I can buy in the market in order to supply my patient.

That does not incentivise behaviours such as holding extra stock or looking at where I might build relationships around resilience. It is very much about driving the price down. Over the past decade, we have seen a significant driving down of the prices of medicines, particularly generic medicines, which has made pharmacies even more focused on that price and the individual cost to them. So there is less funding in the system—less oil in the engine, if I can put it like that—to make sure that pharmacies are able to do that.

The other challenge that has occurred quite a bit is that pharmacies are now often dispensing and supplying medicines at a loss. This means that, when a prescription is presented before them, they may have to purchase the medicine for a certain price when the NHS will reimburse them at a lower cost than what they are purchasing it for. This, again, is a real disincentive for them to hold extra stock and make sure that it is available. They would supply that only at the very last minute, when a patient arrives with a prescription.

To answer your question about what could be done about this, we certainly need to look at a pricing system that means that products are not being supplied at a loss, so that there is sufficient support in there to invest in the core of pharmacy businesses and so that they can hold those extra stocks and stay open—that is, so that the businesses are not closing.

Lord Shipley: Can I ask you about your definition of terms? Is a community pharmacy holding extra stocks the same thing as stockpiling? In other words, if I imagine my local pharmacy, all of its shelves are full. I do not know where they would put extra stock. Presumably, you do not think that community pharmacies should be stockpiling.

James Davies: That is different from holding stock for an individual patient coming through the door. I will give you an example; it is very similar to Malcolm's. Ten years ago, in my pharmacy, I would have kept on the shelf a medication for a patient who would come in once a month. As soon as they had their prescription, I would order it in for the next month and keep it on the shelf for them for a month. Now, I wait until that prescription arrives and order it at the last minute because, as soon as it comes in, I have to pay my wholesaler. Before, I had more cash in the system. That stock on the shelf is a cash cost to me and my business. Previously, there was more cash in the system for me to hold that little buffer and have it available on the shelf. That has all been wiped out. Therefore, it is a lot harder for pharmacies to hold that bit of extra, to have that medicine available and to have that resilience in the system. When there are shocks in the system and price changes, we feel them now a lot more than we ever used to, if that makes sense.

Lord Shipley: It does. Are you in agreement with what Mr Davies said?

Malcolm Harrison: Yes, in part, but I think that there are other incentives and disincentives at play. I am not disagreeing with James at all.

One of the challenges is, as we said, that the fundamental dynamic change is the amount of liquidity in the system. Pharmacies will make decisions based on what they can afford and what they think they will be able to afford going forward. We talked about dispensing at a loss. Is the committee familiar with the model of retained margin? It predicates on there being jeopardy. There is a risk that you will be supplying stuff above what you are going to get paid for it but, on average, there should be sufficient retained margin. There are winners and losers, but every pharmacy should be able to retain sufficient margin to enable them to trade. If there was not—if there was a guarantee that everything you purchased would be remunerated at a greater value—there would be no incentive to buy better because you would know that you are going to make margin. From a taxpayer point of view, the margin system works to keep a lid on prices and to bring things down.

We are finding, though, that prices are so suppressed that that room to buy better is eroding. We are now seeing examples of manufacturers saying, “There’s not enough margin in the system to make it economically viable for me to supply this market”, so they withdraw. That causes a shortage. You then find that the manufacturers that are left in the market can struggle to meet that demand to up production, which means that something goes into short supply. It is supply and demand; it is a commodities market. When supply does not meet demand, price goes up and you see a spike in price. If I know that I am going to get £1 for a pack that costs me £10 to buy, I will question the sanity of running a business where I am buying something for £10 and getting paid £1 for it. That will change behaviours and affect whether people are able to get it or not.

We know that the department works very well with CPE to look at these prices. It introduces concessionary prices. For example, the department says, “Yes, we’ll pay that additional price while it’s in short supply and we wait for the price to come down again”, but there is always lag and a risk of losing out. We talked about regional prescribing habits: you will find that some medicines that go into short supply are heavily prescribed in one region but not in another. Unfortunately, the way the system works is that all of the clawbacks are done nationally, so I may never have supplied a medicine but I am subject to the clawback for it.

As the margins get squeezed and we get closer to the bottom of the ocean, the rocks become exposed and people start to hit those rocks. In terms of incentives, there needs to be sufficient margin for pharmacies to be able to navigate the system to ensure that they are supplying but are not at risk of doing so at a loss. We need the margin to expand so that any increase in drug tariff pricing can flow through, so that wholesalers and manufacturers are incentivised to stay in the market.

Competition builds resistance. If it is a competitive market, manufacturers, wholesalers and pharmacies want to be in that market. They want to compete so that they can deliver and earn a living from it. Obviously, competition also keeps prices down, which is good for the

taxpayer. Competition is really healthy; it provides choice, good prices and so on. When the price is artificially suppressed so greatly, as we are finding now, people leave the market, which means there is not the level of competition you need to build resilience.

Martin Sawyer: I agree with James's and Malcolm's comments about pharmacy. We are finding that we are in a strange situation where pharmacists, because of their funding problems, are procuring at fantastic value for the NHS because for the last couple of years they have been hunting around using electronic platforms to find the cheapest price every five minutes. You would have thought in a shortage situation that the generics price would go up, which it does—concessionary prices cover that—but we are finding that a lot of generics are still not going up in price. Some companies are not pulling out of the market, so the system is almost producing generics prices that are too low because it has become so efficient. The natural curve has not bounced back yet, as we have always expected in previous years, and as has happened in previous years. I guess your future witnesses may know a bit more about this, because the generics market prices are not going back up in some cases and there is plenty of product, which is slightly worrying.

This happened in Holland, for example, when generics were centrally procured. The generics manufacturers wanted to supply Holland, but they agreed to a very low price and wholesalers could not make a margin—this is the disincentive to distribute them—so the Dutch Government now pay wholesalers 50 cents per pack of generics just to get them to pharmacies. We certainly do not want that in this country, because the incentives have driven the system.

In answer to your question, our members survive on margins. Those margins can vary from product to product, so roughly 15% of the products they deliver make a profit and 85% do not, but it is a basket of goods that they are delivering all the time—individualised orders to every hospital, doctor and pharmacy. They can make it work with a mix of brands—off-patent brands, branded generics, OTCs, medical devices as well as medicines. It is a huge mix, but they can make it work.

The challenge for us is that the margin is the incentive. We are dealing with more volume—more medicines are prescribed and dispensed—but the cost of the generic has gone down £1 on average in the past five or 10 years. We are dealing with volumes just to stand still, and the margin is still way below 2% on average, and the cost base is going up. For example, we are investing in technology—we want to—but that is a big cost. There are cash-flow problems. Community pharmacies are not paying their bills. Some 200-plus direct debits are cancelled with pharmacies every month. We have to ask for the money up front. That is completely inefficient. There is hospital debt in UK. NHS hospitals owe us £47 million of overdue debt. We know that the NHS will eventually pay. We hesitate to deal with hospitals, as we have had to deal with community pharmacies as independent businesses, but NHS hospitals' overdue debts are £47 million.

The Home Office is an awful organisation to deal with, with controlled drug licences. We are operating controlled drug premises which we believe could be unsafe because we are relying on a Home Office email. The licence has lapsed; we cannot be inspected; there are no resources in the Home Office to do this. Again, it is a barrier and a cost to us to talk to manufacturers, to say, "You've got to accept this". An international manufacturer will say, "Why should I accept a Home Office licence? I need your certificate. It's out of date", so it considers not supplying some of our members, who sometimes have to shut their premises and distribute from another warehouse just to get by. The Home Office does not recognise resilience in medicines supply. It is just issuing controlled drug licences; every year, we have to get this renewed. Roughly 40% of our controlled drug licences are dependent on the Home Office email.

All these costs are built in—extra, unnecessary things—which if they were tweaked and changed would certainly help. Cash flow is vital to our members, as you can understand, hence the debt problem is a disincentive for companies to get into our sector. That is why there is consolidation. Only the big companies can manage and soak up this problem.

We support the NHS net-zero programme, but how do we change 5,000 diesel vehicles, which have air temperature-controlled diesel cooling systems, to become electric when there are lots of challenges there? I will not go into that. We want to do that as well, but that is a big, important investment for us.

Q39 Lord Mott: I will pick up on the point that you just made, James, about the medicines that you are supplying. In some cases you are supplying at a loss. Is there any evidence that there are some pharmacists which, purely because of financial pressures, are not supplying some medicines to patients? Purely from a cash-flow point of view, is it a choice whether their business survives or does not and they cannot afford to do that?

James Davies: The NHS terms of service mean that they should supply in those situations, but we are aware that they will make that supply only if they can get hold of that product from their wholesaler. Some pharmacies will use 10 or 11 different wholesalers to access their medicines. If you are in a pharmacy that has only one or two wholesalers and your wholesaler does not have that product, you may choose not to supply it or you may not be able to get hold of it to supply. We also see situations where some smaller wholesalers in the market may not buy the product from the manufacturer because they know that the concession price or the price that is currently available is not one for which the pharmacies will be reimbursed. They do not want to hold stock that the pharmacy will not be able to be reimbursed for, so they do not hold the stock and we end up with it not being available all the way through the chain. Ultimately, what it means is that a patient walks into a pharmacy and they are not able to get the medicine that they need.

We also know that lots of pharmacies are continuing to supply medicines at a loss to them. We report that to the Department of Health, and we

discuss it to get price concessions. A decade ago, we would have had a handful of price concessions every month; now we are looking at hundreds every month because we are seeing far more volatility in the market that is causing these problems.

Malcolm Harrison: Ten years ago, there were 195 concessions. Last year, there were 1,640, so the growth is considerable. In answer to your question about whether we have evidence for what they are saying, no, we do not, but, anecdotally, we hear about some larger businesses seeing an uptick in volumes of patients coming for medicines that are priced above drug tariff. When the concession comes in or the tariff changes, the volumes go down again. You can read into that what you will.

Q40 **Lord Laming:** Martin, to clarify, are you saying that neither the Home Office nor the NHS has any rules about how punctually it should meet its bills?

Martin Sawyer: I know there are various public service obligations for public bodies. We have tried the Cabinet Office complaints route, but I think it is done site by site, so it is quite a bureaucratic process. I think some new laws have been introduced this year that are enforcing that—it is called the PPRS, ironically—and we might be able to use that more generally. What we have tended to do is take it up directly with NHS England. For example, we had the same problem in Scotland, and it was sorted out straightaway by the Scottish Government. We can usually identify the trusts; they are quite small in number but obviously it is quite big ones that owe us most of the money. We are trying to do it little by little, but I do not know whether we have any more clout in terms of legislation than that.

For pharmacies, I guess that it is a business contract relationship. We do our best to support community pharmacies, because they are our main customers in number. We sometimes offer credit terms—we take our own credit insurance out now, which we did not used to. We try to work with a pharmacy to support it and manage debt over a longer period. Of course, we are not banks, so it is a bit more challenging, but we do that if we can in a business relationship.

Lord Laming: What is the incentive for the NHS not to pay its bills punctually?

Noble Lords: Cash flow.

The Chair: It has not got the money.

Martin Sawyer: I guess it is just cash flow, in its current financial crisis. In my limited understanding, when my members deal with specific trusts, it literally does not matter what you are dealing with; it is the next bill that they are either going to pay or not. Unfortunately—we have had Department of Health cover on this—we have had in individual cases to say to a hospital, and it is only very occasionally because it is the last thing we want to do, “You need to pay your bill because otherwise you

might affect your deliveries". When we have done that, it has paid the next day.

The Chair: Because it is top of its list then.

Martin Sawyer: But we hate doing that. That is really not what we want to do, because we have relationships with the hospital pharmacy, et cetera.

Lord Laming: It strikes me that the availability of these medicines is so fundamental to the NHS, it must be one of its biggest financial commitments. It deals with it day by day, week by week, month by month. Why is it an issue? I know people will smile and say, "Well, it is cash flow", but actually when you are managing a cash flow of that size there need to be systems in place.

Martin Sawyer: I could not agree more. Some of it is about systems, as you have just described, because different hospitals operate different systems. We have a lot of challenges with the actual invoicing process. We support digitisation but some hospitals—you will find this hard to believe—are still using faxes. We are trying to digitise the payment system, and I think that would help. It is about systems, yes.

Q41 **Baroness Wyld:** I need to confirm that I have no interest to declare in relation to this inquiry. I wanted to ask you about waste of medications. Could you help us to understand, as a committee, how big an issue this is in terms of whether medications could be reused? It would also be very helpful if you could explain the relationship in response to shortages. You have talked about poor prediction of demand, so could you talk about whether a better sense of demand and better procurement strategies might help with that. I am looking to you, Mr Davies.

James Davies: Maybe I should touch on waste medicine. Probably the best evidence we have got is some research I was involved with probably about a decade ago now, which says that around £150 million to £300 million-worth of medicines is wasted in the NHS in England. But when you start to unpick that a little bit further, a lot of that is waste that is there for a legitimate reason—so, somebody started on a medication and they get better and do not need it any more. We have situations where we prescribe medicines at the end of people's lives just in case they need them, and then they pass away and those medicines have not had to be used. In all those situations, we do not know how those medicines have been stored in people's homes. We do not know how they have been used. We do not know whether they have been left on a radiator, in a bathroom cabinet or half-flushed down a toilet, as happens in some cases. So the ability to reuse those medicines is very challenging, because we do not know whether they are to the same sort of safe and effective levels that we want them to be.

If we are thinking about waste within the system overall, there are ways to manage that waste, because clearly those medicines have only been available because there was a prescription issued for them in the first

place. One of the opportunities we have got is to use the existing community pharmacy workforce, and particularly those pharmacists that are becoming prescribers, to say, "Can we look at that repeat prescribing of medication? Can we look at it in a better way so that we are not generating so much waste that is in the system?"

The other thing to consider within this is that, if I am a patient who has concerns that when I turn up to my pharmacy I am not going to be able to get my medication, I am more likely to say, "Well, you know what? I am going to keep an extra box on my shelf, or an extra couple of boxes". If we can stabilise the community pharmacy sector, we can stabilise the whole supply chain and start to reduce some of that waste and that stockholding that is happening at a patient level. During Covid, we did see some situations of a little more medicine reuse—for example, in care homes, where we had a little bit more assurance about how some of those medicines were being stored and how they were being held, there was more opportunity for them to be reused. But in general, when we do not know how they have been stored and how they have been used, it would not be necessarily safe to reuse them and give them back to patients. I think probably covers most of it.

Baroness Wyld: Okay. I will just stay with you, and then maybe the others could answer both questions. In terms of ways of medications being recycled for APIs, do you think that is viable? How much would it cost? Do you think it is a sensible idea?

James Davies: When I think about the majority of medicines that we have talked about and the 850 million packs that are moving around for less than a pound, actually, in some ways it might be cheaper just to incinerate them and go again than it would be to then try and go through that whole process of taking the tablets out, recycling the APIs, and trying to get them out. There are some very specific examples of very high-cost medicines where there may be some opportunity to think about that. But for the vast majority of medicines, actually making sure that we have got a resilient supply chain going with original source medications would probably be a better route for investment.

Malcolm Harrison: Waste is a big issue, we cannot deny it. James has cited some research he was involved in a while ago; I think it was 2010. I suppose the point I am thinking about is that the waste of medicines has unfortunately been around for a long, long time. We know that any medicine that is not taken correctly or not used at all is a complete waste of money. When we are talking about resilience, that money could be better used elsewhere.

Reusing medicines is probably not the solution. It is going to be very costly, to your point. What is interesting is what is creating that waste sometimes. We talk about inappropriate prescribing; we talk about patient behaviours and so on. One thing that we have not touched on yet is how, while we are here to talk about how we can provide resilience in supply, there is another elephant in the room, which is around the demand for medicines. The number of medicines prescribed in primary

care over the last 20 years has doubled. The population has not doubled, so we are using more medicines per head. Going back to the price side of things, the cost of those medicines has not doubled, though. It has only gone up by about 20%, so we can see that the volume of medicine use is being masked and disguised by the suppression of price. Our fear is that we are coming to the end of the point where that price suppression can mask that growth, so we are going to see a real uptick in the cost of supplying medicines if something does not happen. Now, that is not for me to talk about on the demand side of things, but I do think it is an important element of the problem we are facing. How do we understand, recognise and address the demand—the prescribing end—as well as the resilience of the manufacturer to meet that demand?

Martin Sawyer: I will only comment very briefly from the wholesalers' perspective. We are highly regulated, obviously, and want to make sure that pharmacies get safe medicines. We do take back undispensed medicines from pharmacies as long as they have not been delivered more than five days ago. Within five days, a pharmacy can return medicines and the pack can be redistributed to somewhere else. That is a secure part of the supply chain, because we have temperature-controlled distribution to pharmacy, and they can give it back to us in our vans if they do not dispense.

Baroness Wyld: How common is that, though?

Malcolm Harrison: The important part is that it has not gone to the patient. It stayed with the pharmacy for five days. Once it has left the pharmacy, we have no idea how it has been looked after and we cannot reuse it.

Martin Sawyer: That is the barrier. Obviously the pharmacy is a controlled environment, so we respect that. The GPhC and MHRA authorise returns of no more than five days since it arrived at the pharmacy. We take those back. That happens a lot and it is for us a very manual process, because we then have to check every single pack manually, individually. It cannot be automated in any way, so we have a returns department in every warehouse for that purpose, which is highly costly, but it does at least save wasting some medicines.

Baroness Wyld: Does that happen very often? Is there awareness of it across the system?

Martin Sawyer: Yes, all day, every day.

James Davies: There are certainly some returns that are happening to warehouse all the time, but if you take the example that I used earlier of where I might have ordered in a pack and would have it ready for my patient coming back in a month's time, it has been sitting on my shelf, that patient has passed away, it has passed the five-day limit, and I now cannot supply it back to the wholesaler. So I have to keep it on my shelf, ready for—hopefully—another prescription that will fill that.

The Chair: Lord Blencathra, has your question been answered?

Q42 **Lord Blencathra:** It has, but I have a different point. I take Mr Harrison's point about demand. I get the impression that anyone who leaves a doctor's surgery without a prescription for pills feels that they have been underserved. Now, we have had interesting allegories about the rock showing at the bottom of the ocean and what is at fault with the petrol in the car, but it would seem to me the only time the wheels came off was about three years ago when there was a huge shortage of women's hormone medicine. Is that right? I am looking at the BBC website for 22 October, which says "thousands of patients like Youssef"—a guy in Essex—"are struggling to access their medication because of ongoing, unprecedented drug shortages ... for ADHD, cancer treatments, statins, opioid painkillers, anaesthetics and antibiotics". In some cases, it proved lethal: "In 2022, two-year-old Ava Grace Hodgkinson died of sepsis after a pharmacist couldn't amend a prescription for out-of-stock antibiotics". Now, this may not be your bailiwick, but are there any comments you can make on that?

Martin Sawyer: On the HRT issue, which you mentioned first, that happened, I would suggest, because the NICE guidance, which changed the availability, was not communicated to anybody in the supply chain. I know that the Department of Health and Social Care did not even know about the change of guidance, so how could a manufacturer, who takes nine months to scale up, be ready? Demand was turbo-charged, obviously, by social media and the media. We had roundtable meetings with the Minister, with all the manufacturers in the room. One manufacturer built a factory in Belgium just to supply the UK. We did not know this guidance was changing. So that was the HRT issue.

With ADHD as well, the prescription volumes increased dramatically after Covid. The age groups that needed ADHD drugs changed, so they needed different drugs. That meant a huge manufacturing challenge, again. Manufacturers are not necessarily let into the process of being able to forecast demand, perhaps appropriately. You could raise that with them, but I would suggest that those two issues were caused by that. James, I think you wanted to talk about independent prescribing.

James Davies: Yes, for each of the medications, there is probably a different story behind why there was a shortage. In the case of ADHD, there had been a big increase in diagnosis of the condition, not just in the UK but in the US, which led to increased global demand. The US FDA did not want to increase the drug production in that country; it did not want to give the licences. It was a very similar situation with the Home Office licence, which led to a global shortage of the medications being available.

With the pancreatic enzymes—the Creons and things like that—we are still in a shortage situation. Manufacturing production has had to change because pigs, which are the source of where we get the medication, are less fatty now and so they do not have as much of the enzyme as they used to. We have had to extract them in a different way, and that has led to a global shortage.

The tragic case of Ava Hodgkinson was due to a shortage in the supply of amoxicillin. A lot of the shortages that we see in the UK and Europe are related to antibiotics. In that particular case, during Covid, we were not passing on infections to everyone, so the demand for antibiotics reduced. Therefore, some of the factories, in China particularly, reduced their production volumes. When we came out of Covid, we saw a big spike in some of those respiratory diseases. We saw it particularly in children, who needed that suspension. As a result, there was a global shortage. There were problems in France, in the UK and in lots of other countries.

In that particular case, Ava's parents presented with a prescription in the pharmacy for a particular strength of a medication. The pharmacist was not able to change that to a different strength of medication. They do not have the flexibility to make that change. Thankfully, that is being consulted on at the moment, so we will hopefully see some change coming through. From our point of view, the current consultation does not go far enough. It would enable the change to switch between different strengths and different formulations to help support it but, if that prescription came in as a branded medication, we would not be able to make that change.

On the regional shortages, which we have touched on already, we have seen a lot of regional prescribing of branded generic medications. We have seen some of those with Co-codamol, for example, where branded generics have been driven by a particular brand in a particular regional area, mainly driven by cost. That has led to a shortage in that area because we cannot move the supplies around to be able to map to where those demands are being driven by the brands. So the flexibility for pharmacists to be able to make those changes would help to improve the system at the end. One thing I would say as a pharmacist, though, is that I would much rather not have to use that flexibility. I would much rather see that, further up the supply chain, these problems have been addressed.

Malcolm Harrison: I want to make one final point. I totally agree that, for all the shortages that we have been talking about, the pharmacists do whatever they can to make sure the patients get their medicines, and the flexibility changes that are being consulted on will help with that. At the other end of the supply chain, though, where the medicine is manufactured, I think it is really important that we all recognise that the UK is operating in a global market. We have to recognise what happens when there is a shortage for whatever reason—an order will have been placed for the UK market and a batch will fail, for example, and it was manufactured somewhere else in the world. How do we make sure we get alternative stocks into the UK market if we do not have a competitive market, a market that is compelling for a diversion from somewhere else to come into the UK? That is one of the challenges we find. How well can we operate in a global supply chain to ensure that we have the security of medicines that we need?

That comes down to investing in a competitive and stable supply chain in the UK, recognising that 80% of all APIs come from India and China. There is a lot of offshore manufacturing, and that enables the prices to be so low, because consolidation and standardisation allow for efficiency. I am not saying that it is bad the way things are, but we need to make sure that, as a country, we retain the ability to compete on the global market to attract supplies into the country, to try to prevent the shortages, so that the pharmacist does not have to make the changes at the end of the supply chain, because the supply is already coming to the UK.

Lord Blencathra: That ties in with the evidence that we heard earlier about onshoring or at least getting a competitive market. It also strikes a chord with me as, a couple of weeks ago, I had to pick up a prescription for a very close relative. She said, "I can't take this penicillin because I am allergic to it. Can you change it for something of the same strength?" And I was told, "Oh, I can't do that. I can't touch it with a barge pole. You will have to go back to the GP, wait a few days and get a revised one".

James Davies: Yes, and that is incredibly frustrating for pharmacy teams, because they know what the right thing is but they have to go back to the GP, create more work for the GP and send it through the system.

The Chair: I am conscious of time. I have two more people who want to ask questions, and I definitely do not want to start the next session late, given the circumstances. We will have Baroness Coffey followed by Lord Shipley, and then we will call it a day.

Q43 **Baroness Coffey:** It would be really helpful if Mr Sawyer could provide the percentage of returns in response to the question from Baroness Wyld. We heard a few weeks ago, from another witness, that there are financial incentives for pharmacists not to want to basically reissue medication. Is that your view, or is it solely about patient safety?

Malcolm Harrison: Can you clarify what is meant when you say there have been financial incentives to not reissue a medicine?

Baroness Coffey: We have just been talking about waste, with medicine not being used. Over half of medicines are not necessarily used. They get thrown away or whatever, which is not very helpful for chemicals in our water system and the like. One of the suggestions made by a witness is that there are financial reasons or incentives for pharmacists to not want to do it, even if it were permitted.

Malcolm Harrison: I am not aware of any financial incentives to not do that at all. It is not permitted. You mention about stuff being thrown away in the water system, and the reality is that, when a patient returns medicines to the pharmacy—

Baroness Coffey: I know that it is not permitted. I am asking you the question.

Malcolm Harrison: No is the answer to your question. I am not aware of any incentives that would drive a pharmacy to not reuse something, which is a theoretical thing, because they cannot do it anyhow. I am not aware of any financial incentives that would change their behaviour.

Baroness Coffey: Okay, that is all I wanted to ask.

Q44 **Lord Shipley:** Mr Sawyer, you said something about NICE in response to a question from Lord Blencathra. I got the impression that you said that NICE was causing shortages. Is it the case that you think that NICE is causing shortages and, if so, how serious is that?

Martin Sawyer: Apologies for the miscommunication. It was about a particular piece of NICE guidance only, about HRT treatments, which changed—I cannot remember exactly when—a few years ago. Since 2002 there was concern about the carcinogenic potential for HRT treatments, and that was removed from NICE guidance a few years ago. Hence, there was a huge uptake and encouragement, quite rightly, for the use of HRT treatments, but the supply chain was not told about this change in NICE guidance before it was issued publicly. So suddenly manufacturers had to scale up. It takes them, on average, nine months to scale up with a new production line, and they were unable to meet demand.

Lord Shipley: Was this isolated?

Martin Sawyer: Yes.

James Davies: I would just add that that we often see changes to local prescribing guidance implemented, which change the demand for medicines in a particular area without consultation with the supply chain. So it may be that the local formulary has changed, the medications that are used in a particular area have changed, or NICE guidance or other Royal College guidance can change how prescribers are prescribing. That does not necessarily consider the supply chain. We have several examples of that, which we can share afterwards, if that is helpful.

The Chair: Thank you very much. I will skip question 5, but we really would like you to answer it. If you have been thinking about your responses to question 5 in advance, which was about suggesting recommendations, do please let have them by email. I do not want to miss out, but I do not want to start the second session late. This has been a very good session. We have got lots of new information, not only adding to things that we have heard before but with new questions being raised. That is exactly as it should be. We are very grateful for the time you spent with us and for your expertise. Thank you. We close this session now, but anything you have that you came wanting to say and that you can send to us still counts as evidence.