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Pharmacy

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Health and Social Care Committee

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Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

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Prescribing is the most common way of treating patients in the NHS and is the second highest area of spending, after staffing costs. Covid-19 shone a light on community pharmacies - many remained open when people struggled to know where to turn for their health needs. As the health and care system continues to recover from the pandemic, changes to the way in which we all access services are being developed. Pharmacies are at the forefront of that work.

Community pharmacy has fantastic potential to improve access to healthcare and alleviate pressures on the wider health service, but the sector needs better support if that potential is to be delivered. It is currently creaking under the strain of funding pressures, medicine shortages and skill mix challenges.

The current funding and contractual framework for community pharmacy is not fit for purpose. Community pharmacy funding has fallen by over 30% in real terms since 2015. For individual pharmacy owners, this has meant an annual shortfall of at least £67,000 per pharmacy. The number of community pharmacies has reduced by over 1,100 since 2015, of which 34.9% were in the most deprived communities. A complete overhaul of the community pharmacy contractual framework is therefore needed, with a focus on reducing complexity and ensuring mechanisms to fund both dispensing and clinical service delivery, avoiding a situation where one pays for another.

We have also been deeply concerned to hear about the ongoing challenges relating to medicine shortages and the major impacts on patients and pharmacists. People living with type 2 diabetes, ADHD, epilepsy and cystic fibrosis, and those experiencing the menopause, have faced challenges accessing the vital medication they need. Many others are facing similar experiences. Pharmacy teams are dealing with medicine shortages on a daily basis, with some pharmacists spending over four and a half hours per day trying to resolve supply challenges. When purchasing medicines, community pharmacies are exposed to a fluctuating medicines market, which can result in medicine purchases being made in excess of the market cost.

While the overwhelming majority of the 14,000 licensed medicines in the UK are in good supply, the number in short supply has been growing since the start of 2022 and is now double what it was in 2021. The Government must get a grip on these shortages. It is not enough to rely on existing policies, which are clearly insufficient. An independent review of the medicines supply chain must be commissioned to assess the resilience of the supply chain, especially for generic medicines.

When items are out of stock, patients are often directed back to their GP to seek a new prescription for an alternative item. If patients struggle to get their medication, the bread and butter of community pharmacy, it cannot come as a surprise if they are then reluctant to visit for clinical services. Pharmacy First, the Government's flagship policy to free up GPs' time and capacity, will fail if people keep having to return to their GP. Regulations must be updated within three months to allow community pharmacists to make dose and formulation substitutions for out-of-stock items and dispense what they have available, with generic substitution to follow after consultation on implementation to avoid unintended consequences.

Dealing with supply challenges comes on top of pharmacists' wider work dispensing medicines and providing clinical advice, across all settings. The vast majority of pharmacies are now facing staffing shortages. 86% of the pharmacy workforce is at risk of burnout. The Government is right to want to grow the pharmacy workforce, but the necessary training places, and support for those in training, are not available to meet that ambition. With the upcoming 2026 cohort of pharmacy graduates all qualifying as independent prescribers, the Government must ensure they have access to the necessary supervision and that there is work for them to do to use their new skills. There needs to be a specific workforce plan for pharmacy which ensures adequate access to supervision, training, and protected learning time. Pharmacists and technicians must also be added to the list of professions eligible for the Learning Support Fund.

Despite the challenges that the sector faces, there is great ambition to deliver more for patients. The Government and NHS England should match the sector's own ambition and publish a long-term vision for the further development of clinical services in community pharmacy settings. NHS England should commission community pharmacies to deliver the HIV prevention drug PrEP and all routine and seasonal immunisations for adults and children. Any service expansion must be properly funded.

In hospital pharmacy, we saw some incredible innovation at Cleveland Clinic London and the potential benefits that closed loop medication systems could bring to patient care and staff productivity. In the NHS, innovation in pharmacy services is often driven by individual Trust Chief Pharmacists. NHS England needs a more strategic approach, to ensure the benefits of innovation can be felt across England and to consider whether the necessary infrastructure is included within the New Hospitals Programme. An independent review of hospital medicines management should be completed, exploring how the benefits of closed loop medication systems could be more widely realised.

We have been grateful for the positive way in which the whole pharmacy sector has engaged with our inquiry. Their willingness to share their experiences, good and bad, and their suggestions on how to improve things, have been invaluable to us. We are especially grateful to those pharmacists and technicians, from community, hospital and general practice, who joined us on 5th March for our in-person roundtable event. They really brought to life the tension we have seen in our inquiry between the enthusiasm and passion for their sector, and the day-to-day difficulties they face while under financial and time pressure.

Pharmacy professionals clearly want to do their very best for the people who walk into their pharmacy, and the Government has a duty to ensure they are properly supported to do so.

1 Community Pharmacy Funding

1. Community pharmacy is funded through a mix of income streams, summarised in the box below. Community pharmacies provide services under the 2019–2024 Community Pharmacy Funding Framework (CPCF).

Box 1: Community Pharmacy Funding

The NHS Drug Tariff sets out the remuneration and reimbursement that pharmacies can expect from the NHS as part of their contract work under the CPCF. On top of this, many will receive additional income from both NHS and non-NHS sources. Key income streams include:

- fees–community pharmacies get paid a fee on a per-activity basis for delivering certain core services under their NHS contract, e.g., dispensing prescriptions
- payment for advanced and enhanced services–payment for the services they perform for the NHS under their contract, e.g. flu vaccination, smoking cessation services
- payment for other commissioned services–payments for other contracted work, for example as part of locally commissioned services. Unlike most of the other payments listed here, which come from NHS England funding, these are usually paid for by the body that commissioned the service.
- retained margin–the reimbursement rates that community pharmacies receive from the NHS for prescription medicines are set out in the Drug Tariff. Pharmacies buy their medicines from wholesalers and manufacturers at the best price they can. For some medicines, any difference between that price and the Drug Tariff can be retained as profit, known as retained margin. The amount of funding the NHS pays the community pharmacy sector through this margin is capped for each year. The margin encourages cost-effective purchasing which benefits the NHS and the Drug Tariff is regularly updated to reflect changes in the market.
- retail and private services income–many community pharmacies will supplement their NHS income through retail activities–e.g., stocking and selling over-the-counter medicines–as well as for private services.

Although the proportion of NHS and non-NHS income varies between different community pharmacies, NHS income tends to make up the majority of income, particularly for smaller independent pharmacies.

Source: The King's Fund, Community Pharmacy Explained

Community pharmacy real terms funding reduction

2. Throughout the inquiry, we heard about the financial pressures on community pharmacy. Research commissioned by the National Pharmacy Association (NPA) found that one in three English community pharmacies were operating in deficit in 2020.[1] By 2022 funding levels had dropped by over 30% in real terms since 2015, with the proportion of total NHS funding used to meet community pharmacy service costs reducing from circa 2.4% to 1.6% in under a decade.[2]

1 National Pharmacy Association, (PHA0038) para 27
2 National Pharmacy Association, (PHA0038), para 28

3. This has a very real impact on individual community pharmacies. The Company Chemists' Association (CCA) told us that the annual funding shortfall was "at least £67,000 per pharmacy in England".[3] The Independent Pharmacies Association (IPA, formerly the Association of Independent Multiple Pharmacies) went further and told us the shortfall per pharmacy was "around £100,000".[4]

4. During our roundtable with pharmacy professionals, we heard personal stories about the financial strain of running a pharmacy. One participant told us that the repayments on their business loan had increased by £5,000 per month since they had taken it out to buy their pharmacy. Another told us that pharmacists have had to take out overdrafts to be able to afford the medicines they need to dispense,[5] a core function of community pharmacies.

5. We also heard about the possible impact of not addressing these funding challenges. The CCA's February 2024 analysis of NHS data shows that there are now over 1,110 fewer pharmacies in England since 2015. There has been a net loss of almost 400 community pharmacies in England since the start of the 2023/24 financial year. Between 2015 and February 2024, 34.9% of closures occurred in the 20% most deprived neighbourhoods in the country.[6] Jay Badenhorst, then Vice Chair of the National Pharmacy Association (NPA) warned:

> If the network is not sustained and appropriately funded, and at some point that network is not there any longer, we are not going to get it back. Once it has gone, our invaluable asset doing very good public services will be gone.[7]

6. Deborah Evans, Clinic Director and Superintendent Pharmacist at Remedi Health, warned that "increasingly" pharmacies are having to look at providing private services "in order to have sustainable businesses". She posed the question: "What is then the consequence for the NHS service alongside that?"[8]

7. We asked Dame Andrea Leadsom MP, Parliamentary Under-Secretary of State at the Department of Health and Social Care (DHSC), about community pharmacy closures. She told us that " in the year from early 2023 to early 2024, we saw about 1,500 closures and 1,100 new openings" and suggested that because "pharmacies are private businesses … things change. People retire, they want to close, rationalise and so on".[9] Dr Amanda Doyle, National Director for Primary Care and Community Services at NHS England, told us that the "9% reduction over five years in the number of community bricks and mortar pharmacies" had happened alongside "a 9% increase in distance-selling pharmacies". She referred to this as a "balance in a different way of offering a service".[10] While both were keen to highlight that "there are approximately twice as many pharmacies in more deprived areas", the proportion of closures in these areas was not addressed.[11]

3 Company Chemists Association, (PHA0045)
4 Association of Independent Multiple Pharmacies, (PHA0012)
5 Annex: Roundtable event with pharmacy professionals, 5th March 2024
6 Company Chemists' Association (PHA0075)
7 Q7
8 Q91
9 Q176
10 Q184
11 Q178, Q184, Q225

8. Following this evidence session, and the minister's comment that community pharmacy "continues to be a thriving market",[12] Janet Morrison, Chief Executive of Community Pharmacy England (CPE), wrote to us and told us that CPE's recent analysis of the accounts of the top 20 pharmacy companies, and the "testimony of pharmacy owners themselves … says the opposite", describing "declining performance, loss-making and negative net assets".[13]

9. She also highlighted statements at NHS England's October 2022 Board meeting, which contrasted with the views put forward in our evidence session. During that meeting, Dr Amanda Doyle described community pharmacy as "fragile" and told the Board that "it stands to reason that if we want them to really step up to enable it to widen the part they take in delivering primary care services, we do need to consider how we keep that sector sustainable".[14]

A "broken" community pharmacy funding framework

10. Janet Morrison told us that funding pressures are "a direct result of the contractual framework" that pharmacies operate within.[15] Others described the contractual framework as being "broken", in need of "urgent review" and "failing [community pharmacy], the wider sector, the NHS, Government and patients".[16]

11. Witnesses told us about the complexity of the contractual arrangements that business owners must navigate. We heard that Mike Dent, Director of Funding at CPE, spends "an awful lot of time explaining to pharmacies what to expect from the contract".[17] Dr Leyla Hannbeck told us that this complexity was a symptom of the broken framework, saying: "If the NHS makes it way too complicated for pharmacies to be able even to pay their wholesalers bills, it just shows that it is not fit for purpose".[18]

12. Dispensing volumes have grown "significantly", and community pharmacies now dispense over one billion prescription items per year. 60 million more than in 2017/18.[19] Funding for dispensing has not kept up with rising volumes or fluctuations in drug prices. Malcolm Harrison, Chief Executive at the CCA, told us that the fee community pharmacy receives for dispensing, known as the single activity fee, "has not changed since 2016" and is "a closed sum" of £1.3 billion. This means that, as pharmacies dispense more items, the payment attached to each item becomes "less and less", because the overall sum is the same no matter how much dispensing is done.[20]

13. As explained in Box 1, community pharmacies are able to keep some of the profit they make from sourcing medicines at low prices via the retained margin. This is capped collectively, across England, at £800 million. The retained margin incentivises contractors

12 Q178
13 Correspondence to the Committee, 28 March 2024; and Community Pharmacy England, Community Pharmacy England write to Select Committee Chair, 28 March 2024
14 YouTube, NHS England Board Meeting in Common - 6 October 2022 (1:32:57)
15 Q123
16 Company Chemists Association, (PHA0045) and National Pharmacy Association, (PHA0038)
17 Q123
18 Q10
19 Centred Solutions, (PHA0005)
20 Q29

to purchase medicines at the most competitive price available. It encourages manufacturers to produce generic versions of branded medicines once their patent runs out, because they know that through competitive pricing, they will be able to gain buyers in the market.[21]

14. However, we heard how this mechanism can result in some community pharmacies dispensing items at a financial loss. The £800 million retained margin was first agreed in 2014, but has not been reviewed since, while the purchase cost of medicines supplied by pharmacists has increased by 9%.[22] Fluctuating medicine prices can also result in pharmacies dispensing at a loss. We heard that the Drug Tariff (see box 1) does not keep up with fluctuations in medicine prices, creating a disparity between the amount pharmacists pay for medicines and the amount they are reimbursed.[23] Where there are vast differences, CPE and DHSC negotiate a concessionary price, but, Jay Badenhorst explained, even when an "appropriate" price is announced and reimbursement made, flat funding means that, further down the line, community pharmacies are perceived to have made too much money on a particular item, so money is "clawed back" and "overall, [pharmacies] make a loss".[24]

15. Mike Dent told us that the system of price concessions and adjustments is "very overcomplicated" and means pharmacies cannot invest because they do not know if they can keep their earnings until later.[25] We also heard about the element of risk involved in purchasing medicines that pharmacy owners are having to bear. As Jay Badenhorst told us, pharmacists must buy medicines "in good faith that a concession will potentially be granted".[26]

16. We asked witnesses what they would want to see from any contract reform. Malcolm Harrison told us that he believes that community pharmacy needs "a simplified and more stable model that allows businesses to understand what their cash flow is going to be".[27] Mike Dent told us that the "first thing would be to close the gap on funding".[28] He also suggested that the retained margin that community pharmacies have accrued and may owe back to Government might be "impossible" to recover due to pressures on the system. He suggested that the accrued margin should be perceived as "an insurance policy" because it occurred during the Covid-19 pandemic and following Britain's exit from the European Union.[29]

17. Evidence also focussed on the balance between dispensing and service delivery. Mike Dent emphasised that the dispensing of items "needs to be paid for".[30] He told us that there "should not be a cross-subsidy between service payments, for example around dispensing payments and vice versa".[31] Community Pharmacy Lincolnshire's evidence said that the

21 House of Commons Library, Community Pharmacy in England, 12 September 2023, pg. 20
22 Company Chemists' Association (PHA0045)
23 Company Chemists' Association (PHA0045)
24 Q33
25 Q136
26 Q33
27 Q11
28 Q126
29 Q126
30 Q137
31 Q137

funding model needs to be "adjusted" so that it "reflect[s] the modern work of community pharmacy". They suggested that a "model to consider is that in New Zealand where there is a separate funding pot for services and dispensing".[32]

18. In 2023, our Expert Panel completed an evaluation of the Government's commitments on pharmacy in England.[33] One such commitment was to "review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery". The Expert Panel rated the Government's progress on this as "requires improvement" having found that "most stakeholders did not consider that an appropriate review has taken place".[34]

19. **There is clearly something wrong if the funding that pharmacies receive from the NHS does not cover medicine costs, given their core function of dispensing medicines. The Community Pharmacy Contractual Framework is evidently not fit for purpose. It is overly complex and has contributed to the financial pressures that pharmacies are facing. Given the scale and timetable of the Government's stated ambitions for the changing role of community pharmacy, the ways in which pharmacies are funded requires reform urgently to ensure they have the funding to deliver what will be expected of them.**

20. ***We recommend that the Community Pharmacy Contractual Framework (CPCF) is completely overhauled, in close consultation with the community pharmacy sector. Any new framework must:***

a) ***close the gap in funding that community pharmacy has experienced over the course of the current CPCF;***

b) ***focus on reducing complexity and ensure pharmacy owners can clearly understand and predict their cash flow, including de-risking the purchasing price of medicines;***

c) ***ensure funding is explicitly available for both dispensing services and clinical services, to avoid the current situation where one activity pays for another, to the detriment of both;***

d) ***include the capacity for flexibility in the event of increased demand, greater activity or inflationary pressures, for example through indexation.***

32 Community Pharmacy Lincolnshire (PHA0015)

33 The Expert Panel is a group of independent health policy experts appointed by the Committee. At the request of the Committee, the Expert Panel examines the Department's progress on meeting key commitments in specific policy areas. The Committee published the Expert Panel's report on Evaluation of Government commitments in the area of pharmacy in July 2023.

34 Tenth Special Report - Evaluation of the Government's commitments in the area of pharmacy in England (Page 18)

2 Medicine shortages

21. Prescribing medicine is the most common way of treating patients in the NHS, and the over £19 billion annual spend on medicines makes it the second highest area of spending in the NHS after staffing costs.[35] Medicines are therefore integral to our health and care system and because of that, the terms of reference for our inquiry had a specific focus on medicine shortages.

22. As our inquiry progressed, more and more stories came to light through our evidence, and also in the media, of patients struggling to access the vital medication they need.

23. The meaning of a medicine shortage is generally accepted to be a "situation in which patient demand (or anticipated demand) for a particular medicine outweighs the available supply". Shortages can be short or long term and can be at local, national or international level.[36]

24. The Secretary of State for Health and Social Care, the Rt Hon Victoria Atkins MP, told us that "there are around 14,000 medicines licensed for supply in the UK and … the overwhelming majority of those are in good supply".[37]

25. However, we heard that those medicines which are in short supply are having a substantial impact. While the impact on patients is obvious in terms of them not being able to access their vital medications, there are also, as Mike Dent, Director of Pharmacy Funding at Community Pharmacy England, told us, huge hidden costs of shortages.[38] These include the amount of time pharmacists are having to spend dealing with shortages, the time patients have to spend sourcing their own medication, and the knock-on effects shortages therefore have on the wider health and care system.

Pharmacist and Patient Experience

26. In July 2023, pharmacy owners in England rated medicines supply instability as being the most severe pressure facing their businesses.[39] Community Pharmacy England's (CPE) 2024 Pharmacy Pressures Survey[40] showed how medicine supply problems have "become a daily occurrence", with key findings including:

- 99% of community pharmacy staff surveyed encounter supply issues at least weekly and 72% face multiple issues a day.
- 91% of business owners report that their business is experiencing a significant increase in medicines supply chain or wholesaler issues compared to last year.
- 57% of business owners report that their business is seeing a significant increase in the number of patients who have already visited another pharmacy, since last year.

35 NHS England, Health Survey England Additional Analyses, Ethnicity and Health 2011–2019 Experimental statistics, 30 June 2022; NHS England, Medicines Value and Access

36 Suffolk and North East Essex Integrated Care Board (PHA0028)

37 Oral Evidence taken on 25 March 2024, HC (2023–24) 384, Q67 [Victoria Atkins MP]

38 Q146

39 Community Pharmacy England (PHA0060)

40 CPE's findings are the views of owners of over 6,100 pharmacy premises in England, and 2,000 pharmacy team members.

- 94% of pharmacy owners report that their teams now spend more time sourcing medicines compared to last year, and 84% say their teams are spending longer than ever before sourcing medicines.[41]

27. Based on the evidence we received and the testimonies we have heard, these findings, though concerning, are no surprise. During our roundtable with pharmacy professionals, a community pharmacist told us that supply challenges are "the bane of our life".[42] Mark Koziol, Chair of the Pharmacists' Defence Association (PDA), told us that PDA members "now spend four and a half hours a day trying to find one medicine".[43]

28. The public is also suffering as a result of shortages, both in terms of their health and the effort they too have to put into sourcing the items on their prescriptions. William Pett, Head of Policy, Public Affairs and Research at Healthwatch England, shared research which had found that one in four people "struggle to get prescriptions because of shortages". He highlighted the experience of people living with ADHD, 70% of which have "had to ration their medication as a result of shortages".[44] Pharmacists surveyed by CPE also raised concerns about the impact on patients, with 79% reporting patient health being at risk due to shortages.[45]

29. Describing the "practical consequences of shortages in the rigmarole that patients have to go through to get their medication", William Pett told us:

> If they are not going back to their GP to ask for an alternative prescription, they are having to phone around multiple pharmacies, if they can get through. They have to rely on posting desperate messages on local Facebook groups to try to find out from other people in the area which pharmacy is stocking the medications, or they have to play what we call pharmacy bingo by physically traipsing around multiple different pharmacies, going in and asking, 'Do you have this in stock?'[46]

This is clearly an unacceptable situation and we are concerned about the cumulative impact this experience could be having on people's confidence in community pharmacy. In the longer term, we hope to see improvements to IT systems that could provide more live information about where medications are in stock, to avoid patients having to visit multiple locations.

Shortages of medications to treat type 2 diabetes.

30. While there are a number of examples of medicine shortages, one that has been particularly high profile relates to GLP-1 medications (see Box 2) used to treat type 2 diabetes.

41 Community Pharmacy England, Pharmacy Pressures Survey 2024 Medicines Supply Report, 9 May 2024
42 Annex: Roundtable event with pharmacy professionals, 5th March 2024
43 Q106
44 Q76
45 Community Pharmacy England, Pharmacy Pressures Survey 2024 Medicines Supply Report, 9 May 2024
46 Q76

Box 2: GLP-1s products

Glucagon-like peptide-1 receptor agonists (GLP-1s) are a range of drugs used for managing blood glucose levels in people with type 2 diabetes.

There are different GLP-1 RAs for type 2 diabetes. They include:

- Dulaglutide (with the brand name Trulicity)
- Exenatide (with the brand name Byetta or Bydureon)
- Liraglutide (with the brand name Victoza)
- Lixisenatide (with the brand name Lyxumia)
- Semaglutide (with the brand name Ozempic or Rybelsus)

There is also semaglutide with the brand name Wegovy, but this is licensed for weight loss, not glucose management in type 2 diabetes.

Source: Diabetes UK, FAQs - GLP-RA Shortages

31. In July 2023, a National Patient Safety Alert explained that "the supply issues have been caused by an increase in demand for these products for licensed and off-label indications". Helen Kirrane, Head of Policy, Campaigns and Mobilisation at Diabetes UK, told us that there has been a "huge explosion of interest in this type of medication for weight loss globally over the last year or so".[47] The alert told clinicians that "the off-label use of these agents for the management of obesity is strongly discouraged. Existing stock must be conserved for use in patients with diabetes".[48] Helen told us that questions remained about the impact that these safety alerts were having on private prescribing and about the scrutiny and enforcement of measures set out in them.[49]

32. Helen Kirrane described what Diabetes UK had heard from those with type 2 diabetes:

> We have just been hearing devastating stories from people about the emotional toll of not being able to access vital medications, not being able to feel like they can continue, not being able to go to work and to live their daily lives, and not being able to manage their condition effectively.[50]

33. When asked about potential harm to patients of these supply challenges, Helen Kirrane told us that Diabetes UK is "certainly concerned". She explained that the nature of diabetes is that "the complications that can arise … are not immediately apparent" and "develop over time".[51]

34. We were also told that due to the shortages, some patients are having to be initiated on new treatments, often with clinicians in secondary care. This highlights how medicine shortages can impact on the health system beyond primary care. The time that clinicians have to spend initiating new treatments is time being taken away from regular routine diabetes care, "which over the last couple of years has still been really piecemeal across the country and very hard for many people to access".[52]

47 Q148
48 DHSC National Patient Safety Alert, Shortage of GLP-1 receptor agonists, 18 July 2023
49 Q148
50 Q148
51 Q131
52 Q131

Pharmacist substitutions

35. During our inquiry, witnesses repeatedly argued that community pharmacists should be allowed to dispense alternative items when the prescribed item was out of stock, to reduce the impact of supply challenges on pharmacist time and stop some patients having to desperately search for medication. At present, limited substitutions can only happen when there is a Serious Shortage Protocol (SSP) in place.

36. The Human Medicines Regulations 2012 sets out regulations relating to the sale and supply of medicines. Section 214 (1) states:

> A person may not sell or supply a prescription-only medicine except in accordance with a prescription given by an appropriate practitioner.[53]

37. In 2019, the Human Medicines Regulations were amended to introduce serious shortage protocols (SSPs). If the Department of Health and Social Care (DHSC) decides there is a serious shortage of a specific medicine or appliance, an SSP may be issued.[54] SSPs support pharmacists to manage any serious shortages without needing to refer patients back to prescribers. Community Pharmacy England's SSP guidance says:

> The SSP will specify an alternative product or quantity that may be supplied (an alternative strength or formulation, or generic or therapeutic alternative or less of the product) by community pharmacies. Community pharmacy contractors must consider the SSP and, if, in the supervising pharmacist's opinion–exercising his or her professional skill and judgment–the alternative product or quantity is reasonable and appropriate for the patient, they may supply the alternative product or quantity (only as specified in the SSP and subject to any conditions in the SSP), provided that the patient consents/ agrees to the alternative SSP supply.[55]

38. However, we heard that SSPs are inefficient. Boots UK told us that SSPs "are often introduced once an issue has already manifested and also involve overburdensome levels of administration and process".[56] During our roundtable, participants explained that SSPs "often come too late". One participant said that "by the time an SSP is issued, I've already seen at least 50 patients experiencing the same shortage".[57] Duncan Rudkin, Chief Executive and Registrar at the General Pharmaceutical Council (GPhC), acknowledged that it may be time to look at whether "more can be done" with SSPs.[58]

39. Currently, if there is no SSP and the pharmacy cannot dispense the prescribed item, patients are often told to return to their GP to ask for a different item to be prescribed. Allowing pharmacists to make minor changes to prescriptions could avoid this additional step. Duncan Rudkin told us that pharmacists "have a lot of core underlying skills and competence based on … years of over-the-counter prescribing" and suggested that more that could be done to update the legal framework pharmacists operate in to make the most of pharmacists' knowledge and skill.[59]

53 Human Medicines Regulations 2012, section 214
54 NHS Business Services Authority, Serious shortage protocols (SSPs)
55 Community Pharmacy England, Serious Shortage Protocols (SSPs), 03 October 2019
56 Boots UK (PHA0035)
57 Annex: Roundtable event with pharmacy professionals, 5th March 2024
58 Q110
59 Q110

40. The Institute of Health Promotion and Education supports the change which "thereby remov[es] the need to refer patients back to their GP".[60] The Royal Pharmaceutical Society (RPS) highlighted their Medicines Shortages Policy in their evidence to the inquiry.[61] They told us that "to improve patient access to medicines and mitigate the negative effects of medicines shortages", legislation should be amended to allow pharmacists to make prescription substitutions. These substitutions should be for a different quantity, different strength, different formulation and for a generic version of the same medicine (generic substitution).[62] The RPS explained that such substitutions "are used in Scotland for medicines on the recognised shortages list" and "in Wales, the All-Wales Pharmacist Enabling and Therapeutic Switch Policy enables pharmacists to make certain changes to prescriptions without contacting the prescriber".[63]

41. The RPS also told us that the substitutions they call for "have been standard routine practice for pharmacists in secondary care for years".[64] At our roundtable event with pharmacy professionals, one participant highlighted this difference, telling us that "in a hospital, the prescription is just changed. Why is it different in community?".[65] Another participant told us that when a prescription is sent back to the GP surgery where they work, the GP is often asking the pharmacists in the surgery to suggest which alternative to provide, so "why not allow pharmacists to make the change themselves".[66]

42. It appears that the Government and NHS England do not share the views about the limitations of SSPs, or the idea to allow pharmacists to dispense alternative items. David Webb, Chief Pharmaceutical Officer at NHS England, told us that there are already a "range of levers available" to address medicine shortages. He suggested that the advantage of SSPs is that the process includes making an assessment of the "resilience of alternative" medicines, which avoids creating shortages within alternative products.[67]

43. Alongside concerns about creating a knock-on shortage of the alternative, the Government has also raised concern about the impact on patients as part of their explanation of why they "have no plans to introduce legislative proposals to allow pharmacists to amend prescriptions".[68] In a written parliamentary answer, Dame Andrea Leadsom MP wrote:

> Allowing pharmacists to take local action to alter prescriptions could have adverse impacts on patients, because pharmacies will not know the reasons why a medicine has been prescribed, or in what particular way.[69]

Similarly, during our oral evidence session on the Work of the Department of Health and Social Care, Permanent Secretary Sir Chris Wormald, told us that while pharmacists are the medicines experts, "they are not more expert on the patient".[70]

60 Institute of Health Promotion and Education (IHPE) (PHA0007)
61 Royal Pharmaceutical Society, Medicines Shortage Policy
62 Royal Pharmaceutical Society (PHA0025) para 60
63 Royal Pharmaceutical Society (PHA0025) para 61
64 Royal Pharmaceutical Society (PHA0025) para 61
65 Annex: Roundtable event with pharmacy professionals, 5th March 2024
66 Annex: Roundtable event with pharmacy professionals, 5th March 2024
67 Q187
68 PQ 14539, 19 February 2024
69 PQ 14539, 19 February 2024
70 Oral Evidence taken on 25 March 2024, HC (2023–24) 384, Q70 [Sir Chris Wormald]

44. While we note the Government's position on this matter, we are unconvinced that the concerns raised are insurmountable or outweigh the potential benefits. Evidence to our inquiry has called for changes relating to quantity, strength and formulation to be enabled, and to allow for generic substitution. Our evidence has not called for therapeutic substitution. We would suggest that it is this form of substitution that the concerns expressed by the Government predominantly apply to, however we acknowledge that these concerns would need to be addressed in the event of legislative changes to allow generic substitution.

45. We question whether the Government's position on this matter is compatible with the direction of travel towards community pharmacies delivering more clinical services. This would involve pharmacists taking on new responsibilities and learning new skills, yet there appears to be an element of nervousness about allowing pharmacists to have greater autonomy in the area in which they are the experts and have core skills acquired through their training and years of work: medicines.

46. If the Government still has concerns, we would draw attention to the safeguards that the RPS has highlighted in their Medicines Shortage Policy. They write that "changes will be made based on professional and clinical judgement", "pharmacists must be aware that they are responsible for any changes" and that "a thorough consultation" must be held with the patient to "ensure understanding of the necessary change". They further suggest that any amendments will need to be supported by "a robust audit trail" and "clearly made and attributed to the pharmacist making them".[71] We would also note that improvements to IT systems and giving pharmacists access to full medical records would give pharmacists a more comprehensive understanding of their patients, addressing some of the concerns that the Government has about substitution.

47. **Tackling medicine shortages is another vital component in securing the ability of pharmacy to meet its future potential. Medicine shortages cannot be ignored and left to become the norm. The wider implications of medicine shortages for the long-term potential of community pharmacy to take on more clinical work are deeply concerning. The time pharmacy teams are having to spend dealing with shortages is time that they could be spending with patients, and indeed will need to if the clinical role of pharmacists is expanded. Continuing shortages, serious or otherwise, run the risk of eroding public confidence in community pharmacy, with patients frustrated about the service they receive.**

48. **It is also especially worrying that shortages are resulting in patients being directed back into general practice. There is a serious risk that any capacity that general practice gains, through services like Pharmacy First, will be negated by the time spent re-issuing prescriptions as a result of shortages, thus undermining this initiative.**

49. ***We recommend that the Government reviews the effectiveness of Serious Shortage Protocols, with a focus on their timing and their administrative burden.***

50. ***We recommend that regulations are updated within three months to allow pharmacists in community settings to make dose and formulation substitutions for out-of-stock items, subject to the safeguards set out in the Royal Pharmaceutical Society's Medicines Shortage Policy.***

71 Royal Pharmaceutical Society, Medicines Shortage Policy

51. ***We believe that allowing generic substitution would be an important way of reducing the need for patients to return to their GP for out-of-stock medication. We further recommend the introduction of generic substitution, which should follow a government consultation focusing on how best this policy could be implemented to ensure patient safety and avoid the potential for unintended impacts on the supply chain.***

52. ***In their response to this report, the Government should set out what impact it believes National Patient Safety Alerts have on private prescribing and what scrutiny and enforcement measures are in place to ensure private prescribers adhere to these alerts.***

Challenges in a complex global supply chain

53. Of course, our recommendations above will only tackle the impact of the shortages, rather than the shortages themselves. That is why work is needed to understand what is causing shortages and assess what action can be taken to improve the resilience of medicines supply in England.

54. The pharmaceutical supply chain is complex, global and highly regulated. As Dr Rick Greville, Distribution and Supply Director at the Association of the British Pharmaceutical Industry (ABPI), told us, "companies invest heavily in business continuity plans, but shortages are a real risk for any supply chain".[72]

55. Each month, the British Generic Manufacturers Association (BGMA) analyses data from the Government and NHS England to provide a snapshot of supply issues impacting generic medicines.[73] Mark Samuels, CEO of BGMA, told us that they had been "highlighting to ministers since July 2021 the medicine shortage risk".[74]

56. Disruptions to the medicines supply chain can be caused by a number of different factors, which include "manufacturing issues, regulatory challenges, natural disasters, or geopolitical factors".[75] Suffolk and North East Essex Integrated Care Board described how "uplifts in demand contribute to destabilising the supply chain", which can be anticipated, such as those relating to seasonal fluctuations, or could be more widespread and unpredictable, such as when a strep A outbreak meant antibiotics were in short supply across England. They also highlighted supply challenges, including the availability of raw materials and how the conflict in Ukraine has meant some manufacturers have been unable to sustain their processes due to rising inflation, higher energy costs and more expensive raw materials.[76]

57. Malcolm Harrison, Chief Executive of the Company Chemists' Association (CCA), suggests that "medicine security is definitely something that we need to start to consider more".[77] The RPS told us they would "welcome a Government review of the medicines supply chain and identification of where greater support is needed". They suggested that a review should consider the tendering practices in NHS hospitals. Mark Samuels told

72 Q156
73 The latest summary, May 2024, can be found here
74 Q157
75 Alliance Healthcare UK (PHA0033)
76 Suffolk and North East Essex Integrated Care Board (PHA0028)
77 Q12

us that "it takes at least 16 weeks to manufacture a new generic medicine, and often even more than that".[78] It is therefore important that tenders are awarded in good time to ensure suppliers can make the product.

58. For community pharmacy, the RPS suggested that the review should include "whether the current medicines reimbursement regime for community pharmacies is fit for purpose and how pharmacists can be better enabled to ensure patients can access the medicines they need".[79]

59. CPE argued that there is "something fundamentally wrong with the medicines supply chain" and that the Government "needs to get a better handle on the situation to protect both patients and pharmacies". They told us that, because community pharmacies have helped drive down medicines prices by continually negotiating lower prices, the UK is now more vulnerable to the impact of global market shocks.[80] Mike Dent told us that, generally, manufacturers like the UK because it is a large and stable market, which is generally predictable. However, because the price the UK pays for medicines is comparatively cheap on an international basis, when there is a shortage, the UK will not "be top of the list" of places to sell stock to.[81]

MHRA performance

60. Another important factor manufacturers will consider when supplying to a country is their regulatory environment. As Dr Rick Greville told us, manufacturers "always look to the regulator for predictable performance". He observed that the MHRA is currently "struggling to be predictable in different areas".[82] The BGMA told us that the MHRA's performance in licensing generic medicines has declined over the last few years and the licensing timetable has doubled from 12–15 months to 24–30 months or longer.[83]

61. We commend the MHRA on the work that has been done to clear backlogs relating to clinical trials and the efforts made to "stabilise and improve performance" in this area of its work.[84] However, we are concerned about the impact this has had on the MHRA's work in other areas, particularly generics licensing. Mark Samuels acknowledged the progress made with clinical trials, but noted that this "did involve staff being taken off generic licensing and put on to clinical trials processes". We agree with him when he says that "really the MHRA needs to do both".[85]

62. A factor driving these challenges at the MHRA is staff retention. Mark Samuels told us that he had heard that "half of [the MHRA's] pharmaceutical assessors were new in post".[86] He also highlighted the MHRA's loss of European funding and the resulting loss of staff, and told us that "it is the loss of knowhow that goes with losing experienced staff that matters".[87]

78 Q158
79 Royal Pharmaceutical Society (PHA0066)
80 Community Pharmacy England (PHA0060)
81 Q144
82 Q171
83 British Generic Manufacturers Association (BGMA) (PHA0069)
84 PQ 12571, 01 February 2024
85 Q168
86 Q158
87 Q170

63. **The global supply chain for medicines is complex, with a range of different actors involved in getting medicines from the raw materials to the manufacturer to the patient. The Government needs a clearer understanding and overview of the whole process, and the risks at each stage. If the Government already has that clarity, that should be communicated to Parliament. Only then can weaknesses in the chain, their causes, and how to tackle them be truly established so that the Government can get on top of this growing issue and provide the necessary solutions.**

64. ***The Government should commission an independent review of the medicines supply chain. Given the impact that shortages are having, this should be commissioned as soon as possible and completed within 6 months of starting. The review should assess, and suggest ways of improving, the resilience of the supply chain, the performance and role of the MHRA and the impact of prices paid for medicines and community pharmacy reimbursement mechanisms. We recommend a particular focus on the availability and use of generic medicines, though the review should not be limited to these.***

3 Development of pharmacy services

65. It is often said that over 80 per cent of people live within a 20-minute walk of a community pharmacy, and there are twice as many pharmacies in more deprived areas.[88] As the Association of the British Pharmaceutical Industry (ABPI) told us, "community pharmacy represents a 'strategically important setting with great potential to deliver services' and it is in many ways, the most accessible healthcare provider to the general public".[89]

66. The 2019–2024 Community Pharmacy Contractual Framework highlights the Government's ambitions in this area. The Framework states:

> We know that community pharmacists have the potential to play a greater role in clinical service delivery, helping people to stay well. Whilst the supply of medicines remains an ongoing and critical part of what community pharmacy provides, this deal signals the beginning of a fundamental shift towards clinical service delivery, focussed initially on minor illness and the prevention and detection of ill health.[90]

67. Throughout our inquiry, we have been really encouraged by the enthusiasm within the sector to do more for their patients, despite barriers hampering this. At our roundtable event with pharmacy professionals, we heard how there is "now a generation of pharmacists who want to try different things in different settings". Participants from both community and hospital settings told us that they wanted to be able to spend more time with their patients, with one community pharmacist telling us that he "didn't become a pharmacist to check prescriptions and run dispensaries, but [to] be in a consultation room with patients".[91]

68. In hospital settings, we heard from the RPS that "demand for pharmacist expertise continues to increase as medicines-use grows in scale and complexity".[92] Much like in the community, pharmacy professionals in hospitals could be spending more time on clinical services and patient safety, and, as we will go on to discuss, there is great potential for automation and technology to free up pharmacist time to spend on that vital work.

Expanding community pharmacy services

Pharmacy First

69. The Pharmacy First scheme was launched in England on 31 January 2024, having been announced as part of the Government and NHS England's *Delivery plan for recovering access to primary care* in May 2023. Pharmacy First enables community pharmacists to supply prescription-only medicines to treat seven common health conditions without the need to visit a GP.[93] The plan also committed to expanding pharmacy oral contraception

88 Department of Health and Social Care (PHA0018)
89 The ABPI (PHA0022)
90 DHSC and PSNC, The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan
91 Annex: Roundtable event with pharmacy professionals, 5th March 2024
92 Royal Pharmaceutical Society (RPS) (PHA0070)
93 DHSC, Pharmacy First: what you need to know, 1 February 2024

and blood pressure services.[94] The Government believes that these measures could reduce pressure on general practice by saving "up to 10 million appointments a year … equivalent to around 3% of all appointments". They would also provide more choice around where and how they access care.[95]

70. Three weeks after the service launched, we heard from Janet Morrison, Chief Executive of Community Pharmacy England (CPE), about the early stages of the rollout. We welcomed her positive summary of the enthusiasm leading up to the launch, and the experience of pharmacies so far:

> There was a lot of ambition in the sector to make more use of the clinical skills of pharmacists and the pharmacy team to more fully meet the needs of patients … The feedback that we have had since it started has been very positive … In some of the anecdotal evidence, people were saying it felt so satisfying … [It] feels like a really massive resource in terms of meeting pharmacists' professional satisfaction and using all of their skills, not having to refer people away, meeting patient and public need, and being able to relieve that pressure on primary care.[96]

71. But there have been challenges around the delivery of the service. The Pharmacists' Defence Association (PDA), which represents pharmacists, told us of their "significant concerns about the timescales and methods of implementation" of Pharmacy First. The PDA conducted research amongst its members and "98% of respondents reported that they have insufficient staffing to operate existing community pharmacy services". The research also found concern about "competence and confidence" and the PDA told us that "it has been impossible for some pharmacists to complete training for any gaps in clinical knowledge highlighted as part of a competency self-assessment due to course availability or an absence of protected learning time".[97]

72. Research has been commissioned by the National Institute for Health Research "for a robust, wrap-around evaluation of the planned Pharmacy First service to understand the impact, safety, cost effectiveness and acceptability of these services, as well as any implications for antibiotic use and antimicrobial resistance".[98] We look forward to seeing the outcome of this evaluation and will be paying particular attention to the challenges described above, as well as further challenges which we will discuss later in this chapter.

73. Looking ahead, Janet Morrison told us how the expansion of oral contraception and blood pressure services could be built upon. Blood pressure checks could "go into hypertension management, cholesterol management and atrial fibrillation" and that "it would make sense, building on oral contraception, to look at other forms of contraception, HRT, women's health, weight management, PrEP and those sorts of issues".[99] For Pharmacy First, she suggested that other conditions could be added to the seven already included and told us that "the next obvious thing would be chest infections, where it is a

94 DHSC and NHS England, Delivery plan for recovering access to primary care, May 2023, pg. 16
95 DHSC and NHS England, Delivery plan for recovering access to primary care, May 2023, pg. 4
96 Q127
97 The Pharmacists' Defence Association (PDA) (PHA0074)
98 NHS England, Launch of NHS Pharmacy First advanced service, 26 January 2024, para 3.2
99 Q142

one-off minor ailment" that could be dealt with in the pharmacy or referred onwards if necessary.[100] Participants in our roundtable event described chest infections as something they "see a lot and have to refer back to the GP".[101]

Other services

74. There was clear support in the evidence we received for community pharmacy to offer more services, subject to what Janet Morrison described as "the right investment model".[102] CPE summarised the potential service development options that pharmacies could offer. These were grouped into those "supporting self-care and urgent care", "promoting health and wellbeing", "long term condition support and management", and "improving patient safety and cost effectiveness".[103]

75. The British Medical Association highlighted the role that community pharmacy can play in easing pressure on general practice and ensuring "timely access to GP care". They suggest that the Government could do more to promote pharmacy as an alternative for care and treatment including for minor ailments, the monitoring and reviewing of long-term conditions and performing structured medication reviews to ensure patients correctly take and understand their medications.[104]

76. Other contributors made the case for specific services that could be offered in community pharmacy settings. The Stroke Association highlighted the estimated 500,000 people living with undiagnosed atrial fibrillation[105] and the potential for pharmacy to "reduce the health and economic burden of cardiovascular disease". They told us that "pharmacy should be a key system partner for detecting stroke risk factors like atrial fibrillation and high blood pressure".[106]

77. The HIV Commission recommended in 2020 that the HIV prevention pill PrEP be made available in community pharmacies across England and other settings as well as via sexual health services. The Terence Higgins Trust, a Commission founder, told us that pharmacies already dispense emergency contraception and so are well-placed to provide other sexual health care, including PrEP and that the drug's new clinical guidelines would be recommending this.[107] At the time of writing, these guidelines had not been published.[108]

78. More broadly on sexual health, MSI Reproductive Choices UK (a provider of NHS family planning) suggested that "the health and care system could make more effective use of pharmacy" to support the "rising" demand for sexual and reproductive services. They recommended that pharmacists be trained and supported to provide contraception

100 Q150
101 Annex: Roundtable event with pharmacy professionals, 5th March 2024
102 Q125
103 Community Pharmacy England (PHA0060)
104 British Medical Association (PHA0061)
105 Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.
106 Stroke Association (PHA0014)
107 Terrence Higgins Trust (PHA0019)
108 Upcoming clinical guidelines on PrEP from the British HIV Association and the British Association for Sexual Health and HIV will suggest that PrEP provision be commissioned outside sexual health services, including in community pharmacy

and that Integrated Care Boards and local authorities should develop "a framework to establish the most appropriate level of involvement for pharmacy, which may differ based on local needs".[109]

79. The Hepatitis C Trust suggested that community pharmacies are "a key location" for engaging those that need to be reached in order to meet NHS England's target to eliminate hepatitis C by 2025 and maintain elimination. Community pharmacies could play a role "both in terms of testing to find people living with the virus and in terms of harm reduction services to prevent it in the first place". They told us that "people who are at risk of hepatitis C are likely to live within a short walk of a pharmacy and some pharmacies already provide needle and syringe programmes, so may be in contact with people who inject drugs who are at particular risk".[110]

80. Other suggestions came from Marie Curie, which recommended that "community pharmacy services should be commissioned in every local area to provide a standardised set of palliative care medications and make them consistently available 24/7",[111] and the Migraine Trust, which outlined "the role that community pharmacy can play in enabling more cases of migraine to be managed in the community".[112]

81. The role of community pharmacy was also highlighted during the vaccination workstream of our inquiry into prevention in health and social care.[113] In that Report, we agreed with the view that pharmacists have a critical role to play in the delivery of vaccines in order to address access challenges.[114] In their written evidence, the Association of the British Pharmaceutical Industry highlighted the Policy Exchange report *A Fresh Shot* which found that "there is an opportunity for an expanded role for pharmacy in delivering national immunisation programmes, particularly for the adult population which is now familiar with this model of care".[115]

82. **We have been encouraged to hear the enthusiasm within the pharmacy profession to deliver more patient facing care. However, the undoubted potential for pharmacy to improve access to health care, crucially including immunisations, and reduce pressure on general practice and other areas of the health system can only be realised with the right support and the right investment of public funding.**

83. ***We recommend that the Government and NHS England publish a long-term vision for the further development of clinical services in community pharmacy settings within one year. This vision should:***

a) ***include consideration of examples of success within locally commissioned services, and how these could be offered across England***

b) ***build on the seven health conditions covered by Pharmacy First and the delivery of blood pressure and oral contraception services by pharmacists;***

109 MSI Reproductive Choices UK (PHA0042)
110 The Hepatitis C Trust (PHA0037)
111 Marie Curie (PHA0041)
112 The Migraine Trust (PHA0032)
113 For more information about this inquiry, see here
114 Tenth Report of Session 2022–23, Prevention in health and social care: vaccination, HC 1764, para 15
115 The ABPI (PHA0022)

c) ***commit to expanding the role of pharmacists in the management of long-term conditions***

d) ***commit to expanding the role of pharmacists in carrying out medication reviews and supporting medicine adherence; and***

e) ***be supported by a plan setting out timeframes for the delivery of new services and commitments to the allocation of realistic levels of funding to any expansion of services.***

84. ***In the shorter term, and in light of the large body of evidence and long-running calls for these services to be offered in community pharmacy settings, we recommend that NHS England commissions community pharmacies to provide the HIV-prevention medication PrEP and all routine and seasonal immunisations for adults and children.***

Other challenges to address

Pharmacist capacity

85. During our inquiry, we heard from Deborah Evans, Clinic Director and Superintendent pharmacist at Remedi Health, a private healthcare clinic and registered private pharmacy based in Winchester, Hampshire. She suggests that the capacity for pharmacy teams to deliver additional services will be the "biggest issue". This includes both the time needed to complete necessary training, and the time that each pharmacist would need to spend with patients.[116] Mark Koziol, Chairman of the Pharmacist's Defence Association, told us that it can take a pharmacist half an hour to do a detailed assessment of a patient.[117] This is the amount of time Deborah Evans dedicates to each client in her private clinic.[118]

86. Participants in our roundtable event told us that they want to spend more time on clinical services, and less time on dispensary tasks, admin or sourcing medicines. As we discussed in chapter two, pharmacists can spend several hours each day attempting to source medicines. One roundtable attendee said that he wanted to be able to do more prescribing, using his independent prescriber qualification, and thinking around what over-the-counter products were affordable or would be best for the patient, but that there was "no time to do so".[119] Likewise, Deborah Evans told us that they simply would not be able to deliver all the clinical services they provide at Remedi Health if they were also delivering NHS prescriptions.[120]

87. Mark Koziol told us that part of the solution to the capacity challenge was for community pharmacies to move towards being more of a clinical operation and recommended that there should be more than one pharmacist and more technicians and other team members per community pharmacy than is currently the case.[121]

116 Q66
117 Q98
118 Q60
119 Annex: Roundtable event with pharmacy professionals, 5th March 2024
120 Q61
121 Q98

88. The Government sees hub and spoke dispensing as a potential way of freeing up pharmacists and the wider team to focus on other tasks, such as providing clinical services. As part of the Community Pharmacy Contractual Framework 5-year deal, the Government committed to "pursuing legislative changes to enable all community pharmacies to benefit from 'hub and spoke' dispensing models". At present, only pharmacies within the same legal entity can make use of a hub and spoke dispensing structure. The Government launched a consultation in March 2022 to extend this to allow pharmacies in different legal entities to create a hub and spoke system. In May 2024, the Government confirmed that these changes will be made, with a view to proposals coming into force from 1 January 2025.[122]

Box 3: Hub and Spoke dispensing consultation

Hub and spoke dispensing is where parts of the dispensing process are undertaken in separate pharmacy premises. Typically, there are many 'spoke' pharmacies to one 'hub' pharmacy. The concept is that the simple, routine aspects of assembling prescriptions can take place on a large scale in a 'hub' that usually makes use of automated processes. This means that pharmacists and other staff in the 'spokes' are freed up to provide more direct patient care. Currently it is only possible when the hub pharmacy forms part of the same retail business as the spoke pharmacy.

The consultation included proposals on 2 different models of hub and spoke dispensing:

- model 1, where the medicines are returned assembled from the hub to the spoke pharmacy before supply to the patient.
- model 2, where the hub pharmacy supplies medicines directly to the patient.

Source: DHSC, Hub and spoke dispensing, 16 March 2022

89. Our inquiry found some scepticism about hub and spoke dispensing models. One roundtable participant expressed her concern that wider use of hub and spoke could create a "two tier contract" between those who form hub and spoke arrangements and those not in a position to do so. She suggested that there are so many "unknown risks" that it should be "kicked into the long grass".[123] Jay Badenhorst, then Vice Chair of the National Pharmacy Association (NPA), described his experience of a hub and spoke operation for 10 pharmacies located between Newcastle and York. He told us that ultimately, even within one legal entity, there were many elements of the hub and spoke system that they could not make work and, alongside the costs, the gains were "little". He told us that he was considering ending the arrangement and returning dispensing to each individual spoke pharmacy.[124]

90. Malcolm Harrison, Chief Executive of the Company Chemists' Association (CCA), told us that hub and spoke "move[s] the workload", so community pharmacies remain "reliant on … the ambition of the NHS to commission services from them" in order to secure work and funding and maintain access for patients. He also pointed out that, if pharmacies are struggling to make dispensing profitable in their own business, how can they afford to pay somebody else to do it?[125]

122 DHSC, Hub and spoke dispensing, 13 May 2024
123 Annex: Roundtable event with pharmacy professionals, 5th March 2024
124 Q26
125 Q20

91. **It is clear that pharmacists are already struggling to find the time they need for consultations with patients in often busy community pharmacy environments with competing priorities, despite their ambition to do more. Future service expansion must be conscious of the capacity of pharmacists to deliver both existing services, and any planned expansions.**

92. **While hub and spoke arrangements may be beneficial to some pharmacies, we do not believe this is a 'silver bullet' in terms of efficiencies. We urge the Government not to assume that hub and spoke alone will deliver the extra capacity pharmacists clearly need to deliver clinical services. We note the Government's response to their consultation and intention to proceed with plans to allow hub and spoke systems to be set up across different legal entities, but caution against encouraging, or even mandating, more widespread implementation.**

Public awareness and confidence

93. There are also challenges when it comes to encouraging the public to visit their community pharmacy to access health services. Reckitt, a hygiene, health and nutrition brand, cited 2022 research that found that "among those who have visited a pharmacy in the last year only 61% are aware that pharmacies can provide advice about minor health problems and just 27% are aware that they can offer advice on which health service to use".[126]

94. Following the launch of Pharmacy First, the Government and NHS England ran a public awareness campaign, highlighting the conditions included in the service and encouraging people to visit their community pharmacies. Janet Morrison praised the current work and pointed towards "plans for further campaigns later in the year", but emphasised the need for a "continuous commitment" to awareness raising.[127] She told us that she did "not know whether there is commitment beyond this year to continue to market and promote" Pharmacy First.[128]

95. The rollout of Pharmacy First and wider extension of pharmacy services will be a change for the public, as well as pharmacy teams. William Pett raised concerns about the erosion of public confidence in pharmacy services, driven "primarily by medicine shortages, staffing issues and closures".[129] Alongside this, he highlighted the cultural change that the public will need to go through if Pharmacy First is to be a success and the need to be realistic about the time that will take. He explained that "many people are used to seeing their GP as their first port of call … [and] there are going to be some restrictions on how quickly some of those patients will want to take up some of those services".[130]

96. Healthwatch England has published research into Pharmacy First and attitudes to pharmacy services more generally.[131] That research found that the public "were generally positive about going to pharmacy for things like sore throats and earaches" and the likelihood of doing so was high. This was less the case for conditions like shingles and UTIs. Healthwatch heard that one of the "top reasons" people gave for being unlikely to visit the

126 Reckitt (PHA0049)
127 Q133
128 Q149
129 Q62
130 Q62
131 Healthwatch, Pharmacy: what people want, 30 April 2024

pharmacy for those conditions was that "they just prefer seeing their GP".[132] William Pett also spoke about the need to "build confidence among the public that, if you go to your pharmacist, you will be able to get seen for that condition without being referred back to your GP", which he described as a "real frustration" for patients.[133] Encouraging research published by the Company Chemists' Association found that, during the first months of the rollout of Pharmacy First, over 90% of patients eligible for the service received the care they needed, without needing to be referred elsewhere.[134]

97. **Public concerns about being referred back to the GP if they use community pharmacy to access healthcare should ring alarm bells for the Government. It is encouraging that this does not seem to be the experience within Pharmacy First, but we know that medicine shortages are driving people back to their GPs. We are concerned that this reinforces the public concerns.**

98. ***As well as addressing medicine shortages and broadening pharmacists' ability to offer alternatives, to support public confidence and education, the Government should commit to the ongoing promotion of Pharmacy First beyond what has already been announced.***

Appropriate premises: privacy

99. Healthwatch suggested that a lack of privacy might also be a disincentive to using a local pharmacy. They explained that "pharmacies are generally set up as retail premises and, although consulting rooms are available, these may be limited".[135] Similarly, the Royal College of General Practitioners highlighted their concerns about "significant … estates challenges" telling us that they "know that many pharmacy buildings are ill-equipped for consultations, which may have impacts on patient privacy and quality of care".[136]

100. As DHSC minister Dame Andrea Leadsom MP, and NHS England representatives told us, it is "a legal requirement" that pharmacies offering Pharmacy First are able to "offer a private consultation room where people can either have a consultation or discuss an issue, where both the pharmacist and the patient can sit down".[137]

101. Janet Morrison told us that "the vast majority of pharmacies, and those who have registered [for Pharmacy First] will have a consultation room, but it is variable … Some of the pharmacies and the consultation rooms they have built are amazing; some less so".[138] She explained that the "problem" is with community pharmacies' "underlying funding":

> We get paid nothing towards our premises and our facilities. At the moment, given the huge squeeze on finances, any business would be hard-pressed to be able to refurbish its premises and build even better facilities. Many of

132 Q65
133 Q65
134 Company Chemists' Association, The NHS Pharmacy First service - two months in: meeting patient need, 1 May 2024
135 Healthwatch England (PHA0051)
136 Royal College of General Practitioners (PHA0013)
137 Qq200–201
138 Q133

> them did prior to the pandemic, during the pandemic and all of that, but there is more that could be done. We do not get any funding and assistance to do that, so we would like to see that.[139]

102. During our evidence sessions, we discussed the former "Establishment Payment", paid annually to pharmacies in England depending on their dispensing volume. The then Department of Health phased the payment out from 2016 as part of a package of wider reforms to community pharmacy funding and services, which ultimately resulted in the Community Pharmacy Contractual Framework. The decision to remove the Establishment Payment followed concern that it was not a good use of resources. David Mowat MP, then Parliamentary Under-Secretary of State for Health, told the House of Commons:

> [Community pharmacy funding] includes a fixed-sum payment—the establishment fee—of £25,000 per annum which is paid to most pharmacies, regardless of size and quality. This is an inefficient allocation of NHS funds when 40% of pharmacies are now in clusters of three or more, which means that two fifths are within 10 minutes' walk of two or more other pharmacies. There are instances of clusters of up to 15 pharmacies within a 10-minute walk of each other.[140]

When asked if the Government should consider reviving the "Establishment payment" in some form, Janet Morrison explained that it should "certainly be considered as a return" because currently community pharmacies are "relying on the margin portion and perhaps the prescription fee … in order to create the circumstances to invest in buildings, people, staffing, bills and running costs".[141]

103. When this suggestion was put to minister Dame Andrea Leadsom MP, she told us that the "basis on which pharmacy is a private business with a contract with the NHS is the right approach, so that those private businesses can offer other services to members of the public".[142] The minister and NHS England representatives were keen to stress that pharmacies are "private businesses" and "commercial premises" offering private services, such as travel vaccination services "for which they maintain a consultation room". The Government therefore does not believe that "it is right that the taxpayer should take on the burden of updating or upgrading those premises".[143]

104. Dr Amanda Doyle, National Director for Primary Care and Community Services at NHS England, and the minister both pointed towards the £2,000 set-up payment for pharmacies signed up to Pharmacy First.[144] Dr Doyle told us that "part of the set-up payments … is not just about training the staff and getting yourself ready, but ensuring that you can deliver the services that you want to take on from an estate and infrastructure point of view".[145] We are unconvinced that the payment will be able to support community pharmacies in all the ways that Dr Doyle suggests.

139 Q133
140 HC Deb, 20 October 2016, col 970 [Commons Chamber]
141 Q141
142 Q204
143 Q204
144 Qq202–204
145 Q202

105. **Community pharmacies offering clinical services must have private, comfortable spaces in which to see patients. We acknowledge the minister's comments around pharmacies being private businesses, but they are ultimately expected to provide NHS services. As the expanding availability of clinical services in pharmacy settings is encouraged, we believe a more balanced approach is needed to support smaller, particularly independent, pharmacies to keep up with larger ones and have the resources to create the appropriate conditions in which to provide the new services that the Government and the public want to see.**

106. ***We recommend the creation of a new "Establishment Payment" to be paid to eligible community pharmacies to support the development of consultation spaces for patients. This funding should be targeted at pharmacies that are the most reliant on NHS work as their main source of income and could be linked to a commitment to provide an agreed level of NHS service.***

Access to pharmacy during the 'cost-of-living crisis'

107. We also heard how costs of medication could be a barrier to using Pharmacy First. William Pett told us that Healthwatch England's research had found that "one in ten [people] had avoided buying over-the-counter medicine … because of cost" and urged the Government to reintroduce an NHS minor ailments scheme in England.[146] Janet Morrison noted that Community Pharmacy England's 2022 business case for a Pharmacy First service had included free over-the-counter medicines for people on low incomes, which are available in Scotland, Wales and Northern Ireland through the various minor ailments schemes. She explained that, for those on low incomes and eligible for free prescriptions, the cost of the medication is "one of the drivers for people to get a GP appointment" rather than seek support from a community pharmacy.[147]

108. ***To avoid patients continuing to use GPs for support that could be offered in a community pharmacy setting because of concerns about the affordability of over-the-counter medication, we recommend that such medication is free for people on low incomes, as part of the Pharmacy First scheme.***

Digital systems: access to patient notes

109. The integration and interoperability of digital systems within the NHS is a theme that spans the vast majority of our work, and this inquiry is no exception.[148] The CCA told us that the level of digital interoperability within primary care is "severely hindering the ability of pharmacy teams to do more for patients and the NHS".[149] Our written evidence, gathered before the launch of Pharmacy First, repeatedly called for pharmacists to have "read/write" access to patient records to ensure that they are aware of care already given by the GP and to communicate any care that the pharmacist provides.[150] The RPS

146 Q87
147 Q151
148 See also, Eighth Report - Digital transformation in the NHS; Fourth Special Report - Evaluation of Government commitments made on the digitisation of the NHS; Tenth Special Report - Evaluation of the Government's commitments in the area of pharmacy in England;
149 Company Chemists' Association (PHA0045)
150 For example, see The Pharmacists Cooperative (PHA0047), Becton Dickinson (BD) (PHA0016) Matthew Jones (Senior Lecturer in Medicines Safety, Medicines Information and Clinical Pharmaceutics at University of Bath) (PHA0017), Royal Pharmaceutical Society (PHA0025)

highlighted "signs of progress" in the Government and NHS England's *Delivery plan for recovering access to primary care,* but told us that more needs to be done sooner to "make shared care record access a reality across the country" to support better continuity of care for patients.[151]

110. NHS England's service specification for Pharmacy First includes instructions around "accessing clinical records and documentation of Pharmacy First consultations". It states that:

- With the patient's consent, their GP record (e.g. via GP Connect Access Record), national care record, or an alternative clinical record for the patient, must be checked by the pharmacist unless there is good reason not to do so.
- Details and the outcome of each consultation must be recorded on the NHS assured Pharmacy First IT system.
- The pharmacy contractor will ensure that a notification of the provision of the service is sent to the patient's general practice on the day of provision or on the following working day. Where possible, this should be sent as a structured message in real-time via the NHS assured Pharmacy First IT system.
- GP Connect Update Record will provide the functionality to automatically update a patient's GP medical record.[152]

111. Discussing the rollout of Pharmacy First, Janet Morrison told us that she had been "impressed" by the overall ambitions for interoperability of digital systems between community pharmacies and general practice. However she explained that, to meet the Government's ambition to launch Pharmacy First on 31st January, CPE "agreed a minimum viable product" for the digital system to be used. The "ambition is that pharmacies will be able to access the full patient record, to update the full patient record and to make referrals across the whole of the NHS" in due course. She also highlighted the challenges that GP systems will have and urged particular focus on this issue to "make sure that the ambition is driven through".[153]

112. ***When responding to this report, we ask that the Government sets out what progress has been made on rolling out the full digital product for the documentation of Pharmacy First consultations, including the percentage of community pharmacies that have fully functioning and interoperable read/write access to patient records.***

113. ***We recommend that the ongoing evaluation of Pharmacy First includes an assessment of the extent to which pharmacy and general practice digital systems are enabling the necessary data sharing to protect patient safety and ensure continuity of care.***

151 Royal Pharmaceutical Society (PHA0025)
152 NHS England, Community pharmacy advanced service specification: NHS Pharmacy First service pp13–14
153 Qq132–133

Hospital Pharmacy

114. BD, a global medical technology company, told us that "whilst there has been a longstanding policy focus on developing the role of community pharmacy, there has not been a similar, recent focus on hospital pharmacy".[154] This difference is something we saw reflected in submissions received in this inquiry, the vast majority of which was focussed on the community pharmacy sector.

115. Our Expert Panel's evaluation of the Government's commitment on pharmacy included commitments in hospital pharmacy relating to paper and digital prescribing and optimising aseptic services. The commitment to eliminate paper prescribing in hospitals and introduce digital or e-prescribing across the entire NHS by 2024 was rated 'inadequate' overall. The Panel found that poor 'digital maturity' was partly responsible and reported that even prioritised funding for IT systems was insufficient.[155] In their response to the Panel's report, the Government accepted that the deadline of 2024 was "unlikely to be met".[156] Wider changes that are reliant on digital processes, which we will go on to discuss, will not result in equitable benefits if the basics of prescribing are not tackled. We urge the Government and NHS England to redouble efforts to eliminate paper prescribing.

116. Staffing levels in hospital pharmacies were raised during our inquiry. Dr James Davies, Director for England at the RPS, argued for pharmacists on every hospital ward, saying that "where we have pharmacists on the ward … looking at supply of medications, we know that patients get better medicines, they get safer medicines and they get them at the right time, which helps them to move through the hospital faster".[157]

117. This view was shared by a participant at our roundtable event. He told us "it is impossible to ensure that every patient is seen by a pharmacist in hospital" and not always possible for a pharmacist to clinically check discharge paperwork, expressing concern that this could lead to patient harm. He called for an agreed standard for "safe staffing levels" of pharmacy professionals.[158]

118. We will discuss the pharmacy workforce further in chapter 4 of this report.

Hospital medicines management

119. Medicines management is "defined as a series of processes and activities from procurement to medicines administration". Elements of this process can be "directly impacted" by technology, including "prescribing by clinicians at ward level, dispensing and supply in the pharmacy department and medicines storage and administration at ward level".[159] The Automating for Better Care Forum (A4BC), a newly established group co-chaired by Dr Keith Ridge and Lord Carter of Coles, suggested that "there are some 50 different processes that underpin these core elements, all occupying staff time, many of which could be digitised and/or automated".[160]

154 Becton Dickinson (BD) (PHA0016)
155 Tenth Special Report - Evaluation of the Government's commitments in the area of pharmacy in England
156 Thirteenth Special Report - Government Response to the Health and Social Care Committee's Expert Panel: Evaluation of Government's commitments in the area of the pharmacy in England
157 Q47
158 Annex: Roundtable event with pharmacy professionals, 5th March 2024
159 The Automating for Better Care (A4BC) Forum (PHA0071)
160 The Automating for Better Care (A4BC) Forum (PHA0071)

120. BD told us that there is "considerable unlocked value in hospital pharmacy services" and suggested that "faster … more widespread adoption of connected medication management (CMM) technology has the potential to transform workflows and release numerous benefits". BD explained:

> CMM is a term used to describe several digital and automation technologies used in pharmacies and on wards, which, when used together, have the potential to create a closed loop medication management system. For example, hospital electronic prescribing can be fully integrated to the patient record system. The prescribing drives the ordering of medication from the hospital pharmacy. In the hospital pharmacy, automated technologies are used to store, dispense and label medicines, assigning unique barcodes that allow tracking of the medicine as it makes its journey through the hospital and can track use down to individual patients… At ward level, CMM uses secure, automated dispensing, and storage devices, linked to the patient record and administration system, to guide nurses to the medicines a patient is prescribed, speeding up the drug round, whilst the bar code system enables the nurse to confirm the right drug for the right patient. The patient's medication record is updated accurately and automatically.[161]

121. The A4BC Forum suggests that "reducing staff time spent on stock management and introducing bar code driven, closed loop medicines systems … significantly frees up scarce nursing and other staff [time] to spend more time with patients".[162] This should be of particular note in the context of "an ambitious labour productivity assumption of up to 2% (at a range of 1.5–2%)" within the NHS Long Term Workforce Plan.[163] Frimley Health NHS Foundation Trust installed its first pharmacy robot in 2013 and they told us that "the improved efficiency and benefit of reduced picking errors was quicky realised". They compared this experience with another acute hospital site of the same size where they found that "at least six additional members of staff were required" to complete pharmacy orders.[164]

122. In January this year, we visited the Cleveland Clinic, London (CCL) to see their full closed loop medicines management system in action. We discussed the 237 million medicine errors in the NHS every year,[165] and representatives from CCL and BD suggested that there could be a 41% reduction in errors if a closed loop system was introduced. There have been 900,000 administrations of medicines at CCL since its opening in 2022 and only one medication error when an individual by-passed the processes involved in the system. We heard that the key benefits of CCL's system were accuracy, quality and traceability. We would like to take the opportunity to put on record our thanks to all those at CCL and BD who hosted us for such an informative and inspiring visit.

123. NHS England's Chief Pharmaceutical Officer David Webb told us that facilities similar to those at CCL are "available in some NHS trusts now" and that there are "11 global digital exemplar NHS trusts that have some form of closed loop".[166]

161 Becton Dickinson (BD) (PHA0016)
162 The Automating for Better Care (A4BC) Forum (PHA0071)
163 NHS England, NHS Long-Term Workforce Plan, June 2023 (pg.10)
164 Frimley Health NHS Foundation Trust (PHA0076)
165 Elliott RA, Camacho E, Jankovic D, Sculpher M, Faria R. Economic Analysis of the Prevalence and Clinical and Economic Burden of Medication Error in England. BMJ Quality & Safety; 2020
166 Q216

124. Frimley NHS Trust also highlighted the benefits for patient safety that come from "ensuring the right product is dispensed as prescribed to the right patient". Frimley uses medicine cabinets supplied by Omnicell and uses the Epic electronic patient record solution. They told us that the closed loop dispensing system between the two products "means cross checking of patient, medication and prescription can be done digitally [which] has reduced the risk of errors and improved patient safety". They also told us of the benefits to patient experience, saying "patients are more likely to have faster, safer dispensing of medication and therefore a better experience".[167]

125. We were encouraged to hear of the work of NHS England's Global Digital Exemplar (GDE) programme. The programme created a "cohort of digitally advanced exemplar provider organisations … already characterised by relatively high levels of digital maturity, who would share their learning and inspire less digitally mature "Fast Follower" provider organisations". For pharmacy services, the programme initially commissioned nine NHS Trusts as exemplars, and three as Fast Followers. The Trusts involved in the programme have "reached varying levels of digital maturity" by implementing digital systems including Electronic Patient Records, Electronic Prescribing and Medication Administration and automation technologies. These systems would support closed loop medicine administration, barcoded medicine administration and closed loop medicine supply, however no Trust has a "full connected and interoperable workflow". Other Trusts not in the programme have also implemented some of these technologies.[168]

126. NHS England told us that a review of the Trusts commissioned under the programme is underway and we look forward to seeing the results of that work. We note that "there has not been a systematic evaluation of implementing a closed loop medicine system in England" and "there is currently no dedicated national programme and associated funding commitment for further adoption of closed loop medicines systems", and suggest that these may be areas that should be considered as part of any review of medicines management in hospitals, which we discuss later in this chapter. We were also encouraged to hear that the reported anecdotal benefits are in line with those we have heard during our inquiry, namely around improved patient safety and care and enhanced productivity.[169]

127. We heard from David Webb that the ambition around closed loop technology in hospital pharmacy has been "spurred on … by local champions, and to date we haven't had a more systematic approach to things like automated medication storage and robotics".[170] The A4BC Forum told us that "hospital chief pharmacists are seen as the key leaders in this territory" but they will "need help from other senior leaders" if further changes to medicines management are to be delivered. They explained "[T]rust boards must see medicines management as a priority" and while the chief pharmacist will "be central" to delivering the benefits of technology like CMM, "the CEO, finance director, medical director and nursing director must offer visible and tangible support".[171]

128. The A4BC argued that moves towards CMM technology needed "to go further and faster" in the context of "future increased demand, workforce changes and financial pressures, and insufficient engagement of non-pharmacy senior managers and clinicians". They noted that "the last external and comprehensive review of hospital

167 Frimley Health NHS Foundation Trust (PHA0076)
168 NHS England (PHA0077)
169 NHS England (PHA0077)
170 Q217
171 The Automating for Better Care (A4BC) Forum (PHA0071)

medicines management" had been the 2001 Audit Commission report "*A spoonful of sugar–medicines management in NHS hospitals*" and recommended that a new review be commissioned, focussing on "digitally connecting all the elements of medicines management and deploying automation", "monitoring and controlling drug expenditure in a more informed, data driven way", "identifying gaps in the evidence base for the use of connected medicines management technology", setting out "a plan to fill them", and "engaging the wider NHS leadership team in supporting hospital chief pharmacists in deploying connected medicines management technology".[172]

129. The systems that we have described do require new infrastructure and potentially reconfiguring space at ward level, to make room for automated cabinets in clinical areas. We were reassured to hear from David Webb that the New Hospitals Programme is considering this, along with how to accommodate ongoing work in aseptic services transformation.[173]

130. **There are clearly benefits to be found from using automation and technology particularly within hospital medicines management. These benefits could unlock gains in productivity, improve patient safety and free up pharmacist time to work more directly with patients. There are pockets of excellent practice across the NHS, but, outside of formal programmes like the Global Digital Exemplar programme, this is often driven by innovation from key individuals in pharmacy departments and can lack more senior support. To ensure equal access to high quality care, and in the context of the ongoing New Hospitals Programme, NHS England needs to have a more strategic view for how medicines are managed in hospitals across the country.**

131. ***We recommend that an independent review is commissioned to explore hospital medicines management, to report within one year. The review should make recommendations, particularly around how the potential of automation and technological systems like connected medication management could be realised and how learning from Global Digital Exemplars can be built upon in Trusts across England.***

172 The Automating for Better Care (A4BC) Forum (PHA0071)
173 Q218

4 The pharmacy workforce

132. Underpinning much of what we have discussed are the skills, experience and dedication of the professionals who deliver pharmacy services to patients. In this chapter, we focus on pharmacists and pharmacy technicians. We acknowledge and value the vital role that other pharmacy team members, including pharmacy assistants, play in the delivery of services. They are a key part of the skills mix within pharmacies.

133. Alongside evidence we have heard about the great potential of pharmacy to deliver more clinical services and take on more patient facing roles, the challenges that the workforce faces were also described. In Community Pharmacy England's 2023 Pharmacy Pressures survey, 76% of pharmacy team members said their pharmacies were experiencing staff shortages, and 19% of pharmacy owners reported that their pharmacy had been required to close temporarily because of staff shortages.[174]

The NHS Long-term Workforce Plan

134. The NHS Long Term Workforce Plan estimates that education and training places for pharmacy need to grow by 31–55% by 2032/33 to meet demand for pharmacy services. The Plan's ambition is to expand training places for pharmacists by nearly 50% to around 5,000 places by 2031/32. The Plan commits to growing the pharmacy technician workforce and suggests there is potential to expand training via the apprenticeship route. The Plan also states that consideration will be given to a pharmacist degree-apprenticeship.[175]

135. However, we received compelling evidence of significant challenges to meeting these targets for increased training places. Duncan Rudkin, Chief Executive and Registrar at the General Pharmaceutical Council (GPhC), spoke of the need to ensure that there are adequate "numbers, quality and breadth of training placements and the trainers to support those trainees in the future".[176] Community Pharmacy Lincolnshire suggested that financial and administrative burdens associated with hosting pharmacy students could mean community pharmacies simply not offering to take students.[177]

136. Dr James Davies, Director for England at the Royal Pharmaceutical Society (RPS), questioned whether there was enough support attached to the commitments in the Long Term Workforce Plan to deliver places, including in areas they are most needed.[178] This is because, unlike in other professions like nursing, midwifery, dentistry, medicine and others, pharmacy trainees do not have access to the NHS Learning Support Fund. The Fund supports students with funding for accommodation, travel and to support going to different sites for clinical placements. Access to the Fund can therefore encourage students to take up placements in areas where there are particular shortages, help them understand what it is like to practice there and encourage them to take up roles in those areas in the future.[179]

174 Community Pharmacy England, PSNC Briefing 009/23: Summary of the results of PSNC's 2023 Pharmacy Pressures Survey
175 NHS England, NHS Long-Term Workforce Plan, June 2023 (pg.47)
176 Q93
177 Community Pharmacy Lincolnshire (PHA0015)
178 Q45
179 Q44

137. Community Pharmacy Lincolnshire also raised the Learning Support Fund, and other methods of student support, highlighting that pharmacy students do not qualify for any form of NHS bursary, unlike nursing students, or students of other allied healthcare professions. They told us that "making pharmacy the least well financially supported option in health care professions will not solve the current workforce crisis and assist the DHSC in their aim to increase the number of pharmacists trained in the country".[180]

138. Minister Dame Andrea Leadsom MP and Dr Amanda Doyle told us that pharmacy students are not eligible for the Learning Support Fund because the criteria for inclusion was based on "courses that were eligible for an NHS bursary prior to 2017".[181] Minister Leadsom told us that while "these things are always under review", there was no current plan to extend eligibility.[182]

139. **The lack of access to placements, supervisors and adequate financial support is a serious challenge, which could undermine efforts to meet the pharmacy targets set out in the NHS Long Term Workforce Plan. If those ambitions are to be met, there needs to be a greater focus on the availability and quality of the necessary placements.**

140. ***We recommend that the list of healthcare professionals able to access the Learning Support Fund is updated to include pharmacists and technicians.***

Retention and Training

Workforce wellbeing

141. Another theme raised was retention of pharmacy professionals and their development within roles. The Pharmacists' Defence Association (PDA) told us that the key issues influencing pharmacists' decisions about where they work included "understaffing, sub-standard working environments, lack of protected training time and experiences of violence and abuse".[183] The PDA raised concerns that "some pharmacy business owners do not prioritise safe staffing levels", noting that analysis of the community pharmacy workforce surveys showed that support staffing had been cut by 14% in the period 2017 to 2021.[184]

142. Since 2019, the RPS has worked with Pharmacist Support on an annual workforce wellbeing survey. The 2023 survey found that "86% of the pharmacy workforce is at risk of burnout", with underlying factors contributing to poor mental health and wellbeing including "inadequate staffing, lack of work-life balance, lack of protected learning time, lack of colleague or senior support, and long working hours". The results also highlighted "notable sector specific issues", finding that those in community pharmacy were more likely to report their mental health and wellbeing as poor or very poor and were at a much higher risk of burnout than those working in hospitals or general practice.[185]

180 Community Pharmacy Lincolnshire (PHA0015)
181 Q189
182 Q190
183 The Pharmacists' Defence Association (PDA) (PHA0046)
184 The Pharmacists' Defence Association (PDA) (PHA0046)
185 The Royal Pharmaceutical Society and Pharmacist Support, Workforce and Wellbeing Survey 2023, February 2024

143. We also heard from the General Pharmaceutical Council that "some pharmacists and pharmacy technicians do not feel fully empowered to fulfil their potential due to different forms of discrimination, prejudice and racism", which can adversely affect people's wellbeing.[186]

144. The picture that has been painted to us about poor wellbeing amongst the pharmacy workforce is concerning. We agree with the comments that Duncan Rudkin made to us that the "safety of the public and the safety and wellbeing of patients" is "inextricably bound up with the wellbeing of the profession".[187]

Protected learning time

145. As mentioned, a factor raised when discussing retention is personal development and a lack of protected learning time for community pharmacists. A number of participants in our roundtable wanted to see this provided. During oral evidence, Jay Badenhorst, then Vice Chair of the National Pharmacy Association (NPA) highlighted the impact that the lack of protected learning time has on upskilling pharmacists for services like Pharmacy First. He told us that quite often, the introduction of new services meant pharmacists having to complete training "in their own time, at night on a Saturday or a Sunday" which he told us is not the case for those working in, for example, primary care networks.[188]

146. The RPS has also called for dedicated learning time within working hours to allow professionals to complete the training necessary to deliver expanded clinical services, and support career development. They told us that protected learning time should be "equitable for all health professions" and highlighted a pilot of protected time for community pharmacy launched in Wales in 2021.[189] It is unclear what the outcome or results of this pilot were.

Additional Roles Reimbursement Scheme

147. The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 to "improve access to general practice". Through the scheme, primary care networks can claim reimbursement for the salaries (and some other costs) of 17 new roles within a multidisciplinary team, selected to meet the needs of the local population. The scheme includes clinical pharmacists and pharmacy technicians.[190] During our inquiry, it became clear that the ARRS was a point of controversy within community pharmacy.

148. The Company Chemists' Association highlighted "a critical shortfall of community pharmacists in England" and that ARRS money is being used by Primary Care Networks to recruit pharmacists and pharmacy technicians from hospitals and the community setting. They suggested that 8,000 pharmacists had moved into newly created ARRS roles since 2019 and the funding had been "released without sufficient consideration of the impact they would have on other parts of the NHS".[191] In response to a parliamentary

186 General Pharmaceutical Council (PHA0030)
187 Q92
188 Q18
189 Royal Pharmaceutical Society (PHA0025)
190 NHS England, Expanding our workforce
191 Company Chemists' Association (PHA0045)

question in October 2023, then DHSC minister Neil O'Brien MP explained that a total of £839 million had been spent on the ARRS between 2019/20 and 2022/23. Of this, £387 million (46%) was spent on the recruitment of clinical pharmacists.[192]

149. Jay Badenhorst told us that his pharmacy chain had previously had permanent pharmacists working in all branches, but found that, when the ARRS was announced, staff decided that they would need to leave community pharmacy and work in GP practices or PCNS "to pursue their next career move or portfolio work". This meant that his chain ended up running around a third of its pharmacies without a permanent pharmacist.[193]

150. In our Expert Panel's evaluation of the Government's progress made against commitments in the area of pharmacy in England, the Panel found that "the disparity between what community pharmacies and PCNs supported by ARRS funding can pay pharmacy professionals, as well as the working conditions they can provide, is benefitting PCNs at the expense of community pharmacies".[194] The Association of Independent Multiple Pharmacies raised this with us during our inquiry, describing ARRS roles as "perversely out-compet[ing] community pharmacy roles" which "have little to no ability to set the pricing of their services higher to fund more expensive labour".[195]

151. This movement of pharmacists into ARRS roles was also described as a challenge in hospital pharmacy. Richard Bowers, lead clinician in medicines procurement and supply at Leeds Teaching Hospitals NHS Trust, told us that primary care, where ARRS roles are based, "is seen as a far more attractive place to work due to the lack of a requirement to work evenings and weekends".[196] Similarly, the University Hospitals of Leicester NHS Trust told us that the "significant growth" in their vacancy rate was primarily driven by a growth in demand and staff moving into other sectors. They too raised the lack of weekend working, but also highlighted the "relative agility of those smaller employers to make more bespoke and competitive offers on pay" because they are not bound by Agenda for Change, which is the case in secondary care. On training and development, the Trust wanted ARRS to include less senior roles to "ensure that [PCNs] are contributing to training and development, rather than the current model which sees them recruiting predominantly from our early to mid-career staff without making a contribution to the upstream training".[197]

152. Discussing ARRS roles, Dr Graham Stretch, President of the Primary Care Pharmacy Association, told us that the funding for ARRS came from negotiations between the British Medical Association General Practitioners Council and the Department of Health and Social Care on what was "core [general practice] funding", noting that the 2019 NHS Long-Term Plan had committed £890 million annually by 2023 to general practice as part of the inception of primary care networks to fund these additional roles. He also discussed the numbers relating to ARRS roles, community pharmacy and the pharmacist register, pointing out that, at the time of his evidence, 3,057 of the 4,689 pharmacists supported by ARRS came from the community sector. While this "is a significant number", he highlighted that the General Pharmaceutical Council register of pharmacists had grown

192 PQ 202874, 17 October 2023
193 Q13
194 Tenth Special Report - Evaluation of the Government's commitments in the area of pharmacy in England
195 Association of Independent Multiple Pharmacies, PHA0012
196 Mr Richard Bowers (Lead Clinician - Medicines Procurement & Supply at Leeds Teaching Hospitals NHS Trust) (PHA0010)
197 University Hospitals of Leicester NHS Trust (PHA0031)

by 7,308, more than double the number of pharmacists moving from community into PCN. He acknowledged however that the numbers "oversimplify things" and that there has been negative impact on community pharmacy.[198]

Portfolio careers and "one pharmacy workforce"

153. Portfolio careers, and a more integrated pharmacy workforce, were discussed throughout our inquiry. Portfolio careers refers to pharmacists working across different sectors within pharmacy, rather than working in just one.

154. The RPS told us that pharmacy teams "must be supported to enable them to benefit from … portfolio career options" and that enabling pharmacists to work in a range of settings "allows access to pharmacists with the right skills at the right time".[199] Public Policy Projects suggested that a "rotation system" for newly qualified pharmacists could "expose them to the different roles, settings and career opportunities" which may "reduce the numbers leaving the profession".[200]

155. University Hospitals Leicester NHS Trust told us that the future relies on pharmacy reams working effectively across and between sectors. They highlighted roles in Leicester, Leicestershire and Rutland ICB, such as rotational posts across multiple organisations for pre-registration pharmacy technicians, Medicines Optimisation in Care Homes work where pharmacy teams work in both the hospital and care homes, and rotational pharmacist posts with local community and mental health providers.[201]

156. Dr Graham Stretch spoke about portfolio roles while discussing ARRS funding. He told us that he had previously been a clinical director in a primary care network (PCN) and tried to establish a system where the PCN would commission community pharmacy to be the employer and deliver PCN services within community pharmacies. However he had experienced "lots of constraints and rules and regulations around how [to] use the ARRS money",[202] and argued that should be greater flexibility, with "ARRS moneys being used to deliver those services from wherever is best placed to deliver them".[203] Dr Leyla Hannbeck, CEO of the Association of Independent Multiple Pharmacies, also suggested that a multidisciplinary team could be hosted in the community environment "very well".[204]

157. ***The criteria connected to Additional Roles Reimbursement Scheme (ARRS) funding should be reviewed within 3 months to understand whether any additional flexibility could reduce the drain of community pharmacists into primary care networks. The Government should write to us with the outcome of this review.***

198 Qq40–41
199 Royal Pharmaceutical Society (PHA0025)
200 Public Policy Projects (PHA0036)
201 University Hospitals of Leicester NHS Trust (PHA0031)
202 Q40
203 Qq42–43
204 Q14

Independent Prescribers

158. Regulations to allow pharmacists to prescribe independently came into effect in 2006. A pharmacist independent prescriber may prescribe autonomously for any condition within their clinical competence, though this excludes three controlled drugs used for the treatment of addiction.[205] From September 2026 all newly qualified pharmacists will be independent prescribers on the day of registration.[206]

159. Our witnesses were broadly positive about pharmacist independent prescribers. For example, Mark Koziol from the PDA described the independent prescribing possibility as "an astonishingly exciting opportunity for anybody who is thinking of being a pharmacist or is actually a pharmacist".[207]

160. NHS England describes the 2026 changes as "an opportunity" to commission clinical services from community pharmacies incorporating independent prescribing.[208] Whether this could be delivered was a key challenge raised during our inquiry. There was concern about how often existing independent prescribers would be able to use their qualifications and skills in the future. Mark Koziol told us that "in Scotland, the vast majority of independent prescribers still do not use their … qualification on a daily basis".[209] The PDA's written submission suggested that "the strategy as to how pharmacists specifically could be better integrated into patient pathways and build on their current role in a strategic and long-term plan is largely missing".[210]

161. Deborah Evans, Clinic Director and Superintendent Pharmacist at Remedi Health and an independent prescriber herself, highlighted that those qualifying as independent prescribers are finding that there is "no commissioned service within the NHS for them to deliver" and questioned what motivation there is for pharmacies to "invest their own time in that development" when services like Pharmacy First are being delivered using patient group directives. She told us that she is using her independent prescribing to deliver private services and expects others in community pharmacy will be doing the same.[211]

162. Community Pharmacy England's Chief Executive Janet Morrison told us that "the use of patient group directives [in Pharmacy First] is helpful, but the direction of travel should be towards more independent prescribing" and that commissioning of clinical services is needed "to make best use of those independent prescribers".[212] Likewise, the Company Chemists' Association called on policymakers to "provide a roadmap for harnessing the potential" of independent prescribers and told us that "ambitious commissioning is essential if this new pool of clinical skill is to have the biggest impact on the health of the nation".[213]

163. The capacity to support new and existing pharmacists to gain an independent prescriber qualification and receive necessary training when newly qualified, was raised. Mark Koziol told us that there are "not enough qualified independent prescribers in the

205 General Pharmaceutical Council, Pharmacist independent prescriber
206 NHS England, Independent prescribing
207 Q118
208 NHS England, Independent prescribing
209 Q118
210 The Pharmacists' Defence Association (PDA) (PHA0046)
211 Q91
212 Q128
213 Company Chemists' Association (PHA0045)

community pharmacy setting to supervise newly qualified independent prescribers as part of their training".[214] The Pharmacists Cooperative suggested that "fair access" to a DPP[215] was "the main barrier" for pharmacists who want to train as an independent prescriber, and this is especially true for locum pharmacists.[216]

164. The Suffolk and North East Essex Integrated Care Board discussed issues around incentives for training independent prescribers. They told us that funding is required for the "usual 25 hours clinical supervision by a GP or other prescribing pharmacist" and a mechanism to remunerate GPs and existing independent prescribers for this time "may encourage broader uptake and support".[217]

Developing the role of pharmacy technicians

165. Researchers at the University of Manchester, and others, told us about the importance of using pharmacy technicians "effectively" and the need for pharmacists to delegate work to technicians so pharmacists can dedicate more time to clinical duties. They told us that progress on this has been "slow", in part due to a "reluctance" amongst pharmacists to "let go of more time-consuming checking and dispensing issues". They believe that there are lessons to be learned from hospital pharmacy, where delegation of duties has been managed more effectively.[218]

166. We also heard this was important for the development and retention of pharmacy technicians. Nicola Stockmann, Vice President of the Association of Pharmacy Technicians UK, told us that pharmacy technicians need "to be professionally recognised for the autonomous pharmacy profession that they are".[219] This was a message we heard during our roundtable event and we urge all policymakers to be aware of this when thinking about the future of the workforce.

167. Technicians at our roundtable event told us about recruitment challenges in their profession. One participant told us that while pharmacists often talked about the challenges relating to people moving between sectors, for technicians it was about keeping people in the role at all and not losing them to, for example, local supermarkets. They questioned why technicians would want to take on the work of pharmacists "for so little pay", particularly because "working in a dispensary is stressful".[220] The University of Manchester are undertaking research on the reasons why pharmacy technicians are leaving the workforce and have found there are "issues around job satisfaction in community pharmacy, alongside high workloads, low salaries, and limited opportunities for career progression".[221]

214 Q116
215 A Designated Prescribing Professional (DPP) is a healthcare professional with legal independent prescribing rights who supervises someone during their independent prescribing course and provides 'sign-off' on their competency to prescribe. A DPP does not have to be a pharmacist and can be any professional with the independent prescribing qualification.
216 The Pharmacists Cooperative (PHA0047)
217 Suffolk and North East Essex Integrated Care Board (PHA0028)
218 Professor Ellen Schafheutle (Professor of Pharmacy Policy and Practice at The University of Manchester) et al (PHA0039)
219 Q120
220 Annex: Roundtable event with pharmacy professionals, 5th March 2024
221 Professor Ellen Schafheutle (Professor of Pharmacy Policy and Practice at The University of Manchester) et al (PHA0039)

168. The General Pharmaceutical Council told us that that current legislation is "widely perceived as a barrier to the optimal contribution of pharmacy technicians, preventing effective use of pharmacists and the wider skill mix in pharmacy teams".[222] Nicola Stockmann told us that that technicians are "here and ready" to support the delivery of services, but need enabling legislation.[223] Boots UK told us that these changes could "reduce the loss of community pharmacy technicians to other primary care and secondary care roles".[224]

169. Since the conclusion of our oral evidence sessions, the Government has responded to the consultation on patient group directions and is proceeding to amend the Human Medicines Regulations 2012 to enable pharmacy technicians to supply and administer medicines using patient group directions.[225] At the time of writing, it is yet to respond to the recent consultation on changes to legislation relating to the supervision of activities by a pharmacist (see box 4).

Box 4: Changes to legislation relating to the supervision of activities by a pharmacist

This consultation sets out proposals to amend the Medicines Act 1968 and The Human Medicines Regulations 2012. The proposals are to:

- enable pharmacists to authorise pharmacy technicians to carry out, or supervise others carrying out, the preparation, assembly, dispensing, sale and supply of medicines.
- enable pharmacists to authorise any member of the pharmacy team to hand out checked and bagged prescriptions in the absence of a pharmacist.
- allow pharmacy technicians to take primary responsibility for the preparation, assembly and dispensing of medicinal products in hospital aseptic facilities.

Source: DHSC, Pharmacy Supervision

170. During the inquiry, public awareness of the distinct roles and responsibilities of pharmacists and technicians was raised. Nicola Stockmann acknowledged that there is "probably not enough" public understanding of what a pharmacy technician is and suggested that there is "work to be done around that on positive reinforcement from other professions".[226] William Pett, Head of Policy and Public Affairs at Healthwatch England, told us that Healthwatch's research had suggested that patients would welcome increased use of pharmacy technicians, but "only on the basis that they feel informed and aware of the difference between a pharmacy technician and a pharmacist".[227] NHS England's Chief Pharmaceutical Officer David Webb told us that an "important element" of patient awareness was "to do with people wearing badges or other indicators defining the role that they provide, so that the public know who they are speaking to, when they enter any premises".[228] We urge the Government to always consider public understanding when thinking about policy relating to the future development of the workforce.

222 General Pharmaceutical Council (PHA0030)
223 Q120
224 Boots UK (PHA0035)
225 DHSC, Proposal for the use of patient group directions by pharmacy technicians
226 Q105
227 Q86
228 Q213

171. In our 2022 report Workforce: recruitment, training and retention in health and social care, we recommended an integrated and funded workforce plan for pharmacy in order to better utilise the workforce and optimise their workloads. We recommended that the plan ensure access to supervision, training and protected learning time, and highlighted the need to consider the new independent prescriber pharmacy graduates from 2026.[229]

172. **Greater planning and forward thinking continues to be needed around the full pharmacy workforce, accounting for changing roles in the community, increasing demand in hospitals and supporting ICBs to build "one pharmacy workforce" that can be deployed across the full range of pharmacy services within health and social care. As 2026 approaches, when all newly qualified pharmacists will also be independent prescribers, this will become ever more urgent.**

173. ***We reiterate that an integrated and funded workforce plan for pharmacy must be developed and laid before Parliament within 12 months. This should focus upon delivery of the targets set out in the NHS Long Term Workforce Plan. The pharmacy specific plan must:***

a) ***ensure that all pharmacists have adequate access to supervision, training, and protected learning time, along with clear structures for professional career development, including to support those who wish to complete independent prescribing courses.***

b) ***consider that from 2026 all newly qualified pharmacists will be independent prescribers and ensure that these graduates are given protected learning time, adequate supervision, career development opportunities and that there are commissioned services available so they regularly make use of their IP qualification.***

c) ***set out a clear vision for the further development of the role of pharmacy technician, and action that will be taken to deliver it.***

174. ***We further recommend that any workforce planning, be it at a national or ICB level, should ensure the appropriate and safe complement, and mix of skills, in all settings, including hospital wards as highlighted by Dr James Davies of the Royal Pharmaceutical Society. This should include consideration of the need for more than one pharmacist per community pharmacy in relation to the delivery of initiatives such as Pharmacy First.***

Conclusions and recommendations

Community Pharmacy Funding

1. There is clearly something wrong if the funding that pharmacies receive from the NHS does not cover medicine costs, given their core function of dispensing medicines. The Community Pharmacy Contractual Framework is evidently not fit for purpose. It is overly complex and has contributed to the financial pressures that pharmacies are facing. Given the scale and timetable of the Government's stated ambitions for the changing role of community pharmacy, the ways in which pharmacies are funded requires reform urgently to ensure they have the funding to deliver what will be expected of them. (Paragraph 19)

2. *We recommend that the Community Pharmacy Contractual Framework (CPCF) is completely overhauled, in close consultation with the community pharmacy sector. Any new framework must:*

    a) *close the gap in funding that community pharmacy has experienced over the course of the current CPCF;*

    b) *focus on reducing complexity and ensure pharmacy owners can clearly understand and predict their cash flow, including de-risking the purchasing price of medicines*;

    c) *ensure funding is explicitly available for both dispensing services and clinical services, to avoid the current situation where one activity pays for another, to the detriment of both*

    d) *include the capacity for flexibility in the event of increased demand, greater activity or inflationary pressures, for example through indexation.* (Paragraph 20)

Medicine Shortages

3. Tackling medicine shortages is another vital component in securing the ability of pharmacy to meet its future potential. Medicine shortages cannot be ignored and left to become the norm. The wider implications of medicine shortages for the long-term potential of community pharmacy to take on more clinical work are deeply concerning. The time pharmacy teams are having to spend dealing with shortages is time that they could be spending with patients, and indeed will need to if the clinical role of pharmacists is expanded. Continuing shortages, serious or otherwise, run the risk of eroding public confidence in community pharmacy, with patients frustrated about the service they receive. (Paragraph 47)

4. It is also especially worrying that shortages are resulting in patients being directed back into general practice. There is a serious risk that any capacity that general practice gains, through services like Pharmacy First, will be negated by the time spent re-issuing prescriptions as a result of shortages, thus undermining this initiative. (Paragraph 48)

5. *We recommend that the Government reviews the effectiveness of Serious Shortage Protocols, with a focus on their timing and their administrative burden*. (Paragraph 49)

6. *We recommend that regulations are updated within three months to allow pharmacists in community settings to make dose and formulation substitutions for out-of-stock items, subject to the safeguards set out in the Royal Pharmaceutical Society's Medicines Shortage Policy.* (Paragraph 50)

7. *We believe that allowing generic substitution would be an important way of reducing the need for patients to return to their GP for out-of-stock medication. We further recommend the introduction of generic substitution, which should follow a government consultation focusing on how best this policy could be implemented to ensure patient safety and avoid the potential for unintended impacts on the supply chain.* (Paragraph 51)

8. *In their response to this report, the Government should set out what impact it believes National Patient Safety Alerts have on private prescribing and what scrutiny and enforcement measures are in place to ensure private prescribers adhere to these alerts.* (Paragraph 52)

9. The global supply chain for medicines is complex, with a range of different actors involved in getting medicines from the raw materials to the manufacturer to the patient. The Government needs a clearer understanding and overview of the whole process, and the risks at each stage. If the Government already has that clarity, that should be communicated to Parliament. Only then can weaknesses in the chain, their causes, and how to tackle them be truly established so that the Government can get on top of this growing issue and provide the necessary solutions. (Paragraph 63)

10. *The Government should commission an independent review of the medicines supply chain. Given the impact that shortages are having, this should be commissioned as soon as possible and completed within 6 months of starting. The review should assess, and suggest ways of improving, the resilience of the supply chain, the performance and role of the MHRA and the impact of prices paid for medicines and community pharmacy reimbursement mechanisms. We recommend a particular focus on the availability and use of generic medicines, though the review should not be limited to these.* (Paragraph 64)

Extending pharmacy services

11. We have been encouraged to hear the enthusiasm within the pharmacy profession to deliver more patient facing care. However, the undoubted potential for pharmacy to improve access to health care, crucially including immunisations, and reduce pressure on general practice and other areas of the health system can only be realised with the right support and the right investment of public funding. (Paragraph 82)

12. *We recommend that the Government and NHS England publish a long-term vision for the further development of clinical services in community pharmacy settings within one year. This vision should:*

    a) *include consideration of examples of success within locally commissioned services, and how these could be offered across England*

    b) *build on the seven health conditions covered by Pharmacy First and the delivery of blood pressure and oral contraception services by pharmacists;*

c) *commit to expanding the role of pharmacists in the management of long-term conditions*

d) *commit to expanding the role of pharmacists in carrying out medication reviews and supporting medicine adherence; and*

e) *be supported by a plan setting out timeframes for the delivery of new services and commitments to the allocation of realistic levels of funding to any expansion of services.* (Paragraph 83)

13. *In the shorter term, and in light of the large body of evidence and long-running calls for these services to be offered in community pharmacy settings, we recommend that NHS England commissions community pharmacies to provide the HIV-prevention medication PrEP and all routine and seasonal immunisations for adults and children.* (Paragraph 84)

14. It is clear that pharmacists are already struggling to find the time they need for consultations with patients in often busy community pharmacy environments with competing priorities, despite their ambition to do more. Future service expansion must be conscious of the capacity of pharmacists to deliver both existing services, and any planned expansions. (Paragraph 91)

15. While hub and spoke arrangements may be beneficial to some pharmacies, we do not believe this is a 'silver bullet' in terms of efficiencies. We urge the Government not to assume that hub and spoke alone will deliver the extra capacity pharmacists clearly need to deliver clinical services. We note the Government's response to their consultation and intention to proceed with plans to allow hub and spoke systems to be set up across different legal entities, but caution against encouraging, or even mandating, more widespread implementation. (Paragraph 92)

16. Public concerns about being referred back to the GP if they use community pharmacy to access healthcare should ring alarm bells for the Government. It is encouraging that this does not seem to be the experience within Pharmacy First, but we know that medicine shortages are driving people back to their GPs. We are concerned that this reinforces the public concerns. (Paragraph 97)

17. *As well as addressing medicine shortages and broadening pharmacists' ability to offer alternatives, to support public confidence and education, the Government should commit to the ongoing promotion of Pharmacy First beyond what has already been announced.* (Paragraph 98)

18. Community pharmacies offering clinical services must have private, comfortable spaces in which to see patients. We acknowledge the minister's comments around pharmacies being private businesses, but they are ultimately expected to provide NHS services. As the expanding availability of clinical services in pharmacy settings is encouraged, we believe a more balanced approach is needed to support smaller, particularly independent, pharmacies to keep up with larger ones and have the resources to create the appropriate conditions in which to provide the new services that the Government and the public want to see. (Paragraph 105)

19. *We recommend the creation of a new "Establishment Payment" to be paid to eligible community pharmacies to support the development of consultation spaces for patients. This funding should be targeted at pharmacies that are the most reliant on NHS work as their main source of income and could be linked to a commitment to provide an agreed level of NHS service.* (Paragraph 106)

20. *To avoid patients continuing to use GPs for support that could be offered in a community pharmacy setting because of concerns about the affordability of over-the-counter medication, we recommend that such medication is free for people on low incomes, as part of the Pharmacy First scheme.* (Paragraph 108)

21. *When responding to this report, we ask that the Government sets out what progress has been made on rolling out the full digital product for the documentation of Pharmacy First consultations, including the percentage of community pharmacies that have fully functioning and interoperable read/write access to patient records.* (Paragraph 112)

22. *We recommend that the ongoing evaluation of Pharmacy First includes an assessment of the extent to which pharmacy and general practice digital systems are enabling the necessary data sharing to protect patient safety and ensure continuity of care.* (Paragraph 113)

23. There are clearly benefits to be found from using automation and technology particularly within hospital medicines management. These benefits could unlock gains in productivity, improve patient safety and free up pharmacist time to work more directly with patients. There are pockets of excellent practice across the NHS, but, outside of formal programmes like the Global Digital Exemplar programme, this is often driven by innovation from key individuals in pharmacy departments and can lack more senior support. To ensure equal access to high quality care, and in the context of the ongoing New Hospitals Programme, NHS England needs to have a more strategic view for how medicines are managed in hospitals across the country. (Paragraph 130)

24. *We recommend that an independent review is commissioned to explore hospital medicines management, to report within one year. The review should make recommendations, particularly around how the potential of automation and technological systems like connected medication management could be realised and how learning from Global Digital Exemplars can be built upon in Trusts across England.* (Paragraph 131)

Pharmacy Workforce

25. The lack of access to placements, supervisors and adequate financial support is a serious challenge, which could undermine efforts to meet the pharmacy targets set out in the NHS Long Term Workforce Plan. If those ambitions are to be met, there needs to be a greater focus on the availability and quality of the necessary placements. (Paragraph 139)

26. *We recommend that the list of healthcare professionals able to access the Learning Support Fund is updated to include pharmacists and technicians.* (Paragraph 140)

27. *The criteria connected to Additional Roles Reimbursement Scheme (ARRS) funding should be reviewed within 3 months to understand whether any additional flexibility could reduce the drain of community pharmacists into primary care networks. The Government should write to us with the outcome of this review.* (Paragraph 157)

28. Greater planning and forward thinking continues to be needed around the full pharmacy workforce, accounting for changing roles in the community, increasing demand in hospitals and supporting ICBs to build "one pharmacy workforce" that can be deployed across the full range of pharmacy services within health and social care. As 2026 approaches, when all newly qualified pharmacists will also be independent prescribers, this will become ever more urgent. (Paragraph 172)

29. *We reiterate that an integrated and funded workforce plan for pharmacy must be developed and laid before Parliament within 12 months. This should focus upon delivery of the targets set out in the NHS Long Term Workforce Plan. The pharmacy specific plan must:*

    a) *ensure that all pharmacists have adequate access to supervision, training, and protected learning time, along with clear structures for professional career development, including to support those who wish to complete independent prescribing courses*

    b) *consider that from 2026 all newly qualified pharmacists will be independent prescribers and ensure that these graduates are given protected learning time, adequate supervision, career development opportunities and that there are commissioned services available so they regularly make use of their IP qualification.*

    c) *set out a clear vision for the further development of the role of pharmacy technician, and action that will be taken to deliver it.* (Paragraph 173)

30. *We further recommend that any workforce planning, be it at a national or ICB level, should ensure the appropriate and safe and mix of skills in all settings, including hospital wards as highlighted by Dr James Davies of the Royal Pharmaceutical Society. This should include consideration of the need for more than one pharmacist per community pharmacy in relation to the delivery of initiatives such as Pharmacy First.* (Paragraph 174)

Annex: Roundtable event with pharmacy professionals, 5th March 2024

On Tuesday 5th March, the Committee held a roundtable event in Westminster and online. We invited 29 pharmacy professionals to share the challenges they face in their day-to-day roles, and their ambitions for the future of their role. We heard from pharmacists, technicians and students from across England, with varying levels of seniority and with experience working in community, hospital and general practice pharmacy.

A summary of the discussions that were had, organised by theme, is below. Participants in the roundtable are anonymous and the below paraphrases what was said, with some direct quotes indicated with inverted commas. The Committee would like to express its thanks to all those who took part in this event.

Theme: Workforce

- When asked what tasks take up the majority of their time as a pharmacist, one participant said that they "firefight rather than plan, train and inspire".
- A PCN pharmacist told us that there is now a generation of pharmacists who want to try different things in different settings and that policy from Government and NHS England needs to recognise this.
    - One participant suggested that there are too many disparities within what being a pharmacist or technician involves. They wanted to see roles standardised so that people have similar experiences and are trained to similar levels. For example, they referred to taking on new pharmacists or technicians in their PCN and there being varying levels of knowledge eg around how to complete blood forms.
    - A community pharmacist wants to see "parity of esteem" across primary care and across sectors and encouragement of portfolio careers.
    - For technicians, a participant called for the establishment of cross-sector roles "to make pharmacy technician roles more interesting".
- There was discussion around "showcasing" the role that pharmacy professionals play in the health service. For example, one participant suggested that pharmacists need to be treated "as valuable in their own right" rather than as a way of "helping" other professionals with their workloads, eg GPs.
    - Participants suggested that there needs to be greater recognition of, and education around, the different roles within pharmacy.
    - Another participant suggested that technicians are seen as "back office support" but that NHS Trusts "could not survive without [them]".
- One pharmacist summarised the challenge for pharmacists being that there are "pharmacies who can do a lot, but there are lots of reasons why they can't". The participant said there is "a need to create an enabling environment to do

this: vision, infrastructure, time, funding". They said that people are doing a lot "under a lot of strain" and they may "not break" but the "quality of ambition diminishes".

- A Chief Pharmacist at a large NHS Trust told us that it is "impossible to ensure that every patient is seen by a pharmacist in hospital" and that it is not always possible for a pharmacist to clinically check discharge letters. They expressed their concern that this could lead to harm to patients.
  - The participant believes that there needs to be "safe staffing levels" for pharmacists and there should be pharmacists on every ward. They suggested that each Trust is different in terms of how much money is dedicated to pharmacy, which could exacerbate health inequalities.
- Participants discussed the potential of Independent Prescribers to do more: "Why are Independent Prescribers having to use PGDs"? Participants spoke of being contractually unable to prescribe on the NHS without being part of a pathfinder programme. A lack of a "clear vision for what independent prescribing will look like in the community" was raised.
  - Participants expressed concern that, with the 2026 graduates having IP qualifications as standard, community pharmacy could lose a lot of workforce.
  - Another expressed concern about "a two-tier system" because not all pharmacists will have had the opportunity to get the IP qualification.
  - On training, a participant highlighted that "you can't find supervisors for people who want to be independent prescribers" and that this "is a big problem" in their area. They have had an issue with recent graduates being unable to find supervisors, which is creating a bottleneck for students. They suggested that this challenge exists before even considering the needs to upskill the existing workforce.
- A community pharmacist described how their profession "often hits brick walls" in terms of their development and the service they can offer. They explained that they moved to General Practice to enable them to complete their IP training. They also spoke about wanting to be able to prescribe more without having to refer back to a GP.
  - One participant expressed their frustration that community pharmacists spend time, money and effort training pharmacists, but they get to a particular level and then have to go elsewhere to be able to develop their skills further.
- One PCN pharmacist said that "General practice would not cope without pharmacists". Acknowledging the general sentiment of hesitancy from GPs towards pharmacists taking on their work, they said that the sentiment is not shared by GPs that actually have worked with pharmacists.

- The movement of workforce from community to general practice was acknowledged, however two participants said that in their experience, people do return to community pharmacy because they "are bored" and "miss the patient interaction" that they would get in the community setting.

- We heard that pharmacists in hospital settings are having to work to convince their Trust to be more "pro-pharmacy" and to dedicate resources to implement recommendations made, eg those of the Royal College of Emergency Medicine that there must be a dedicated pharmacist in all emergency departments.

    - A participant suggested that little progress has been made in implementing this recommendation and there needs to be a concerted effort to push forward with it.

- A pharmacy technician highlighted challenges with recruitment and retention in their profession. While pharmacists had been talking about the challenge of people moving between community and general practice, the participant said for technicians this was about keeping them in the profession entirely, and not losing them to, e.g, local supermarkets.

    - They expressed concern about the desire of pharmacists to pass on many of their tasks to technicians because "why would a technician take on extra work for so little pay" and explained that "working in a dispensary is stressful". They suggest that if pharmacy technicians are to take on more, they need to be better paid and funded. Another participant wants technicians to be seen not just as "there to support pharmacists" but as "professionals in their own right".

    - Another participant highlighted recruitment challenges in their area, where they have around 300 technicians for 6,000 pharmacists, saying there "are not enough [technicians] to go round". They explained how local funding constraints had led to limits to recruitment this year, and no recruitment of apprentices. This has meant that training for technicians has slowed, because the training is unaffordable, and this will "exacerbate the workforce crises".

    - Similarly, another participant described the recruitment situation in their area, where NHS England released a "very tight deadline of possible funding to advertise, interview and recruit pharmacy technician candidates for 2024/25". They explained that funds were not released in time, which resulted in a loss of candidates and the missing of that year's college intake that has ultimately meant that their area does not have trainee pharmacy technicians for the coming year. They said that "this will not help the already national shortage of pharmacy technicians".

- Discussing the future of the pharmacy technician role, a participant suggested that there are regulatory barriers to realising the potential of technicians and consultations to remove those barriers are "taking far too long". Referring to the consultation to allow technicians to supply and administer medicines using patient group directions (PGDs), and how this could mean technicians being able to administer vaccines, the participant explained that pharmacies are already

planning for the next flu season but don't yet know whether the regulations will change. They explained that it will be too late to adjust plans if the regulatory changes are made.

- A participant spoke about overall workforce planning: "no one has given a number" to say how many people are needed to carry out particular roles across pharmacy staff groups. "This is why there is no strategy and proper management of workforce".
  - Concerns were raised about the ability to meet the ambitions of the NHS Long-Term Workforce Plan–one participant praised the recognition of the need for more training posts, but suggested there still needs to be adequate time to provide that training and that there is a "huge" cost pressure of £10,000 per trainee and resource is needed.
  - Concern was also raised that "increased clinical roles in pharmacy are being offered without proper workforce plans or a pharmacy strategy".

Theme: Education and training

- On pharmacy education, participants wanted to see protected learning time for pharmacy professionals, which is not available in community pharmacy.
- One participant working in academia suggested that community pharmacists don't generally want to take on pharmacy students, and that the quality of placements in community pharmacy is variable, but "much better" in hospitals. They suggested that the "package" for the community pharmacies to take on students in "not attractive enough".
  - Another said that pharmacists are reimbursed £23 per day for a student, whereas other medics come with a £50 per day reimbursement.
- A PCN pharmacist highlighted the disparities between how trainee GPs and trainee pharmacists are treated. He explained that the PCN receives funding per trainee, with additional money for a continued professional development grant and for taking on an educational supervisor role. This is unlike pharmacy trainees, where PCNs "essentially have to pay to take on a pharmacy trainee" (because of the costs involved).
  - They also highlighted that there is a "very long" list of professions that are eligible for the NHS Learning Support Fund but that it doesn't include pharmacists. Another participant highlighted that pharmacy is the third largest workforce but has no access to the Learning Support Fund.
  - Another comparison between professions was that, while portfolio careers were being encouraged they were not facilitated effectively in contrast to the rotation system for newly qualified doctors.
- Discussing the education of pharmacy technicians, a participant said that "they would like to see a more even playing field between primary and secondary care and the community pharmacy sector". They explained that in the secondary

sector "there is good educational infrastructure". In community, there are "pockets of good practice", but for the majority, trainees "struggle to get through the programme" or they "struggle to get protected learning time" or "supervisors have no knowledge about education or training standards".

- On education more widely, one participant highlighted that hospitals have a member of staff responsible for education and training, which is not available in community pharmacy and means that, for example, "apprentices don't have the security of someone who can prioritise or champion them". They recommend that a role should be introduced with specific responsibility to train apprentices in the community. This shouldn't be "the supplementary focus of a manager" but have its own dedicated person.

- One participant suggested that there is a desire to increase placements so that students can understand the impact of what they're learning and implement it, but the system can't cope with the number of students and there are not enough places.

    - They suggested that it might be helpful if there was a "specified period" for how many weeks a pharmacy placement should be. This would "set an expectation" for what was required. They acknowledged that there would still remain challenges around finding placements.

- Participants raised a lack of consistency in terms of the educational support received by staff and the "very different staffing and educational quality" between pharmacies in the community, even within the same chain.

    - One participant suggested that pharmacy technicians are not used to their full potential because there is "no trust in their training or education"

- Discussing undergraduate pharmacy students, a community pharmacist said they "struggle to find work experience" and suggested that they should be able to "come to community pharmacy and work while studying" to give them a better experience and to help with the pharmacy's workload.

- A participant who is a representative of pharmacy students said that, while the current student body comprised the future of the profession, there was great uncertainty about what services they would end up being asked to provide and what they will really be tested on in exams or training.

Theme: Pharmacy services

- There were a number of criticisms of the openness of PCN and ICB consultation and decision-making to pharmacy input. One participant asked why pharmacy didn't seem to have the profile and influence suggested by the scale of the medicines budget, the proportion of health care activity it represented, or the assumptions behind Pharmacy First.

- Community pharmacy pharmacists told us that they want to be able to spend more time on clinical services, and less time on dispensary tasks, admin or sourcing medicines.

  - An independent prescriber working in community pharmacy in particular wants to spend more time using their qualification and prescribing. They believe there are things that are done in general practice that could be done in community pharmacy, for example support for patients with well managed chronic conditions, taking on monitoring, ordering and analysing blood tests and adjusting doses as required.

  - A community pharmacist said that he didn't "become a pharmacist to check prescriptions and run dispensaries, but to be in a consultation room with patients". Another said that he wants to be there to do more prescribing and thinking around what medications are affordable or what would be best for the patient, but there is no time to do so.

  - A community pharmacist suggested "there is a sense of trying to deliver a population health management agenda" whilst trying to navigate competing priorities: "pharmacy is front line and most accessible for the population, but day to day life is often spent dealing with bureaucratic issues".

- A PCN pharmacist explained how he had recently dealt with 50 patients in the practice who needed blood pressure checks, suggesting this could be done in community pharmacy instead.

- A hospital pharmacist said that, especially in hospital settings, the senior pharmacists could perhaps take more responsibility and apply their skills and knowledge to 'dispensing-to-diagnosis' rather than simply filling prescriptions.

- Participants discussed what might be next for Pharmacy First, in terms of other conditions. Some highlighted chest infections as something that pharmacists see a lot but have to refer back to the GP, so there is potential to add that to the list of conditions.

  - One participant suggested that they would rather focus efforts on prescribing for long term conditions, not acute work. They felt that pharmacists aren't trained to a sufficiently high level to do acute work and would need to be at the level of, for example, advanced nurse practitioners. The participant would be more comfortable with chronic/long-term conditions where there would be specific guidelines and flowcharts to follow.

- One participant discussed their first month of Pharmacy First. They had 43 consultations, 10 of which fell under the conditions in Pharmacy First and of those 10, 7 received antibiotics. The rest received self-care advice. The participant discussed the amount of time pharmacists spend giving this kind of advice.

  - Another spoke about limitations caused by lack of space in community pharmacies: "we cannot see patients because we don't have rooms" for one to one consultations.

- A pharmacist suggested that pharmacy is viewed as "a commodity". They questioned who is looking at the standard of pharmacy services being provided and suggested that pharmacy needs to be seen not as a "nice to have" but as a "critical part" of the national health care system.

- Participants described how the Discharge Medicines Service is underutilised and there is the potential for it to be used more widely. One participant spoke of receiving only 2 referrals per month, another received many more but when put in the context of the size of the area they served, it seemed small.
- One participant questioned why people are not discharged to a pharmacy by default.

Theme: Funding

- The approach to pharmacy funding was challenged by participants, for example one suggested that "the community pharmacy approach where they make money from private sources is outdated" and their work "is mostly NHS work".
  - Some spoke about the stress of having to maintain a business and the pressures associated with funding that doesn't cover all their bills. They were concerned about the ability to pay for staff when the living wage increases. All agreed that "this is no way to run a healthcare setting".
- One community pharmacist described how they felt like "pharmacy is done on the cheap"; another participant said pharmacy had been "pared to the bone".
  - Another suggested that there is "a contractual model where burden and risk is all on the contractor".
  - Another asserted that much that was valuable and productive in pharmacist/patient interactions was "invisible" to the funding system.
- Discussing the personal financial challenge that pharmacists take on, one pharmacist shared that their business loan has recently increased by £5,000 per month.
  - Another said that "due to a lack of funding and being a new contractor" there has been a "significant increase in bank interest" which means that the loan taken out to buy the pharmacy "is now very expensive".
- The financial impact of pharmacy closures on those that remain open was raised. One participant described how, in their area, 3 branches of a high street chain had closed, serving 15,000 patients. A third of them transferred to this participant's pharmacy and, despite an increased customer base, they had made a loss in January because of the need to buy more stock, making assumptions about how much was needed and which medications would be needed.
  - Another explained that pharmacists have to take out overdrafts to be able to afford drugs, particularly due to issues with patient flows.
  - A further impact mentioned—also a workforce issue—was that junior pharmacists were being put off by the financial and operational pressures from continuing in the sector.

- Participants discussed the challenge of the way that concession pricing works, with one explaining how they can often miss out on concession prices because they don't put the claim in in time.
- Another spoke about the lack of consistency around dispensing income and how much they will be paid month to month. They said, for example, they are often "not sure why they made £30,000 less one month than another" and the lack of consistency means they "can't plan for new staff or trainees" and "can't offer the services we want to".
- A participant suggested that there has "never been a vision from NHS England for community pharmacy". They said that without this, the Treasury "doesn't have the motivation to assess what funding is needed". This results in the system functioning in "survival mode". They suggest that thinking about structural change is necessary, but "more important is a vision" that shows how to bring the pharmacy asset to it's full potential.
- A community pharmacy contractor (and pharmacist) raised concerns about staff wages and said there needs to be something in place to ensure that when minimum wage goes up, pharmacy funding is increased.

Theme: Patient Experience

- We heard that community pharmacy is a "totally untapped resource". A community pharmacist explained that the people who know about it and have relationships with their pharmacists use it often, but those who don't know about it, or haven't experienced good service, do not use community pharmacy.
- One participant spoke of their love of community pharmacy, especially the impact they can have on patients in their community that they have known for their whole life. Another lamented the threat to the time available to build and maintain these 'precious and valuable relationships' from financial and other pressures.
- Discussing where the public is when it comes to Pharmacy First and accessing healthcare more in community pharmacy settings, one community pharmacist said that "patients get aggy when they have to be sent to the GP" and that the "public are ahead of the system" in terms of their expectation about what a pharmacist can do.
- Participants accepted that changing attitudes towards community pharmacy could take time for those who have rarely, if ever, used community pharmacy and visit their GP for health concerns. One participant said it was their hope that GPs would refer more people to pharmacies, they will have a good experience of care and then will know to go back for other needs.
- One pharmacist explained how they are unable to "give social value" because they are "so worried about funding structure". They are unable to "champion patients, talk through hospital or other clinical letters", which are things "that we used to do and are well placed to do".

- One participant suggested that pharmacies should have a registered list of patients whose journey across the health system the pharmacist can therefore follow.
- A pharmacist working in academia but also in A&Es said that he sees people "who shouldn't be in A&E, they needed some advice and education from their community pharmacist".
- A pharmacist working in a hospital setting explained that patients will often say that the reason they are "stuck in hospital" is that they're waiting for a pharmacist. However, the participant explained that often it is due to a lack of a prescribing doctor, so "all the pressure is put on [the pharmacy team]". They suggest that more work needs to be done around patient flow in acute care to support discharges and reduce ambulance waits.

Theme: Medicine shortages/supply challenges

- A community pharmacist described supply challenges as "the bane of our life" and that patients think it's "all our fault".
- Another suggested that community pharmacists should be able to make basic changes to prescriptions when an item is out of stock.
  - There was widespread agreement on this point. Others described frustration at not being able to give, e.g. 2x20mg tablets instead of 1x40mg tablets and frustration about GPs prescribing branded generic medications. The pharmacist often has a range of alternatives in stock but can't supply them because the branded generic was prescribed.
  - A PCN pharmacist described how GPs often ask the pharmacist which alternative medicine they should prescribe, so why not allow pharmacists to make the change themselves. Participants highlighted that GPs are not medicines experts. They also described a Whatsapp group that they use to gain intel on stock levels of particular medicines, which they then feed back to the GP to influence prescribing.
  - Participants also highlighted the disparity with hospital pharmacists: "In a hospital, the prescription is just changed. Why is it different in community?"
- Discussing Serious Shortage Protocols (SSPs), participants explained that these are limited and they often come too late. One participant said that "by the time an SSP is issued, I've already seen at least 50 patients experiencing the same shortage".
- Describing the challenge of the impact of shortages on prices, one community pharmacist explained that wholesalers "hike their prices overnight" so medicines have to be given out at a loss. They said that they feel that community pharmacy is "propping up the NHS drugs bill as a charity case" and suggests that if nothing is done, the NHS might "lose the goodwill of pharmacy, who do a lot of free work".

- Another participant expressed concern about there being "too many steps" when setting prices through discussions with Community Pharmacy England, rather than pharmacists dealing directly with wholesalers.
- Participants suggested that there is a need for the Government to look at a consistent medicines supply chain across both community and hospital pharmacy.
- The environmental impact of medicine shortages was also highlighted to us, with one participant discussing the impact that the need to use more cartons when splitting medication boxes, additional dispensing and checking time and increasing deliveries is having on CO2 emissions.
- One participant suggested more should be done to tackle the wastage and the misuse of prescribed medicines (with the former valued at about £300m per year and the latter representing about £500 million of lost health benefits).

Theme: Medicine Errors

- Discussing the role pharmacists and technicians play in checking prescriptions, participants described pharmacy as an "unseen profession" in that it often prevents harm from happening in the first place.
- Participants discussed the high number of hospital admissions that are medication related.
- A pharmacy technician suggested that more needs to be done to understand how many admissions are averted because of the work of pharmacists picking up medication errors–there is no measurement of how much time and cost and resource pharmacists and technicians are saving the NHS because they pick up errors and prevent readmission.
    - From their own experience, they believe it could be that 75% of drug charts are wrong. Not all errors are life threatening, but all are wasteful.
- One pharmacy technician highlighted that technicians pick up "huge numbers of medication errors in dispensaries" and there is little time to fix those errors.
- One participant stressed the importance of effective supervision of dispensing and that it must be maintained in the face of distractions such as chasing short supplies or queries with GP surgeries.
- A PCN pharmacist highlighted research by Elliot et al (2021) that found 237 million medication errors occur at some stage in the medication process in England. The research is titled "Economic analysis of the prevalence and clinician and economic burden of medication error in England".
- When asked about things they spend a lot of time doing that they wish they could spend less time doing, one participant highlighted "sorting out problems caused by bad prescribing".

- To support patients, one participant suggested that there should be "a standardisation of all manufactures to have pack sizes to reflect the 28 days prescription cycles".

Theme: Technology

- One community pharmacist said that new technology had great potential and seemed to be developing in the right direction to increase collaboration and break silos. However it seemed pharmacy had a greater appetite for change than GPs and pharmacists were not always 'at the table' when new systems were discussed.
- A PCN pharmacist spoke of their frustration about the lack of technological links between their local community pharmacies and the PCN–the PCN wants community pharmacies to have access to more patient information.
  - Similarly, a community pharmacy pharmacist wanted to be able to feed back to GPs via patient notes.
  - Another suggested a single patient record to reduce additional workload created by having to email GPs with any changes or safeguarding concerns.
- A community pharmacist raised the variation in IT infrastructure and particularly electronic prescribing. They suggested that the challenges around interoperability and the sharing of information "introduces risk".
- Participants described the day-to-day challenges they face around IT infrastructure. One described "constantly phoning up [IT support] because the system has crashed" and highlighted challenges when trying to access blood test results that had been done in a different county. They couldn't access that information and had to phone around to try and resolve that, which they described as "inefficient".
- One participant wanted to see a single standardised system used across the board.

Theme: Hub and Spoke

- Participants were sceptical about hub and spoke. One participant said that it's important "not to lose sight of what the point of pharmacy is" and that there are "too many unknown risks" so it "needs to be kicked into the long grass". She suggested that it creates "a two-tier contact" because not all pharmacies would be in a position to take up the option of using hub and spoke.
- Another participant said that they had "not known anywhere" that Hub and Spoke works, the hubs are "not built where patients are" and "the flows don't work".
- One participant however did see some benefits to parts of the dispensing process being off-site, for example blister-pack checking.

Formal minutes

Thursday 23 May 2024

Members present:

Steve Brine, in the Chair

Chris Green

Rachael Maskell

Pharmacy

Draft Report (*Pharmacy*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 174 agreed to.

Annex agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Adjournment

Adjourned till a time and day to be notified by the Chair.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 21 November 2023

Jay Badenhorst, Vice Chair, National Pharmacy Association; **Dr Leyla Hannbeck**, Chief Executive, Association of Independent Multiple Pharmacies; **Malcolm Harrison**, Chief Executive, Company Chemists' Association — Q1–37

Dr Graham Stretch, President, Primary Care Pharmacy Association; **Dr James Davies**, Director for England, Royal Pharmaceutical Society — Q38–58

Tuesday 16 January 2024

Deborah Evans, Clinic Director and Superintendent Pharmacist, Remedi Health; **William Pett**, Head of Policy, Public Affairs and Research, Healthwatch England — Q59–91

Mark Koziol, Chair, The Pharmacists' Defence Association; **Duncan Rudkin**, Chief Executive and Registrar, General Pharmaceutical Council; **Nicola Stockmann**, Vice President, Association of Pharmacy Technicians UK — Q92–122

Monday 19 February 2024

Mike Dent, Director of Pharmacy Funding, Community Pharmacy England; **Janet Morrison**, Chief Executive, Community Pharmacy England; **Helen Kirrane**, Head of Policy, Campaigns and Mobilisation, Diabetes UK — Q123–155

Dr Rick Greville, Director, Distribution and Supply, The Association of the British Pharmaceutical Industry (ABPI); **Mark Samuels**, CEO, British Generic Manufacturers Association (BGMA) — Q156–177

Tuesday 26 March 2024

Rt Hon Dame Andrea Leadsom MP, Parliamentary Under-Secretary of State (Minister for Public Health, Start for Life and Primary Care), Department of Health and Social Care; **Dr Amanda Doyle OBE**, National Director for Primary Care and Community Services, NHS England; **David Webb**, Chief Pharmaceutical Officer for England, NHS England — Q178–226

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

PHA numbers are generated by the evidence processing system and so may not be complete.

1 Alliance Healthcare UK (PHA0033)

2 Ampong, Lambert (PHA0008)

3 Association of Independent Multiple Pharmacies (PHA0065)

4 Association of Independent Multiple Pharmacies (PHA0012)

5 Buttercups Training Ltd (PHA0050)

6 Bayer Plc (PHA0058)

7 Becton Dickinson (BD) (PHA0016)

8 Bennett, Martin (Chairman / Superintendent Pharmacist, Associated Chemists (Wicker) Ltd, T/A Wicker Pharmacy) (PHA0009)

9 Boots UK (PHA0035)

10 Bowers, Mr Richard (Lead Clinician - Medicines Procurement & Supply, Leeds Teaching Hospitals NHS Trust) (PHA0010)

11 British Generic Manufacturers Association (BGMA) (PHA0069)

12 British Medical Association (PHA0061)

13 British Specialist Nutrition Asssociation (PHA0053)

14 Brutons Pharmacy (PHA0011)

15 CONNECT Care – the digital medicines experts (PHA0029)

16 Centred Solutions (PHA0005)

17 Community Pharmacy England (PHA0073)

18 Community Pharmacy England (PHA0060)

19 Community Pharmacy Lincolnshire (PHA0015)

20 Company Chemists' Association (PHA0045)

21 Company Chemists' Association (PHA0075)

22 Denham, Sarah (Principal Healthcare Consultant, Wilmington Healthcare) (PHA0048)

23 Department of Health and Social Care (PHA0018)

24 Edwards Lifesciences (PHA0062)

25 Frimley Health NHS Foundation Trust (PHA0076)

26 General Pharmaceutical Council (PHA0067)

27 General Pharmaceutical Council (PHA0030)

28 Haleon Plc (PHA0020)

29 Healthcare Distribution Association UK (PHA0027)

30 Healthwatch England (PHA0051)

31 Healthwatch Milton Keynes (PHA0003)

32 HubRx Ltd (PHA0023)

33 Institute of Health Promotion and Education (IHPE) (PHA0007)

34 Jones, The future of community pharmacy in England: policy, stakeholder and public perspectives Matthew (Senior Lecturer in Medicines Safety, Medicines Information and Clinical Pharmaceutics, University of Bath) (PHA0017)

35 Lawton, Mr Gregory (PHA0068)

36 Lawton, Mr Gregory (PHA0055)

37 MHA (Methodist Homes) (PHA0052)

38 MSI Reproductive Choices UK (PHA0042)

39 Marie Curie (PHA0041)

40 Moderna Biotech UK Ltd. (PHA0040)

41 NHS Confederation (PHA0043)

42 NHS England (PHA0077)

43 NHS Resolution (PHA0064)

44 National Pharmacy Association (PHA0038)

45 PAGB, the consumer healthcare association (PHA0034)

46 Patel, Hemant (PHA0057)

47 Pfizer UK (PHA0059)

48 Pharmacy2U (PHA0026)

49 Public Policy Projects (PHA0036)

50 Reckitt (PHA0049)

51 Royal College of General Practitioners (PHA0013)

52 Royal Pharmaceutical Society (PHA0066)

53 Royal Pharmaceutical Society (PHA0025)

54 Royal Pharmaceutical Society (RPS) (PHA0070)

55 Saatchi, Miss Ameneh Ghazal (Senior Partnership and Policy Manager, Public Policy Projects) (PHA0006)

56 Schafheutle, Professor Ellen (Professor of Pharmacy Policy and Practice , The University of Manchester); McDermott, Dr Imelda (Research Fellow, The University of Manchester); Willis, Dr Sarah (Senior Lecturer in Healthcare Management, The University of Manchester); Jacobs, Dr Sally (Lecturer in Pharmacy, The University of Manchester); Astbury, Dr Jayne (Research Associate, The University of Manchester); and Hindi, Dr Ali (Lecturer in Pharmacy Practice, The University of Manchester) (PHA0039)

57 Stroke Association (PHA0014)

58 Sue Ryder (PHA0024)

59 Suffolk and North East Essex Integrated Care Board (PHA0028)

60 Terrence Higgins Trust (PHA0019)

61 The ABPI (PHA0072)

62 The ABPI (PHA0022)

63 The Automating for Better Care (A4BC) Forum; and The Automating for Better Care (A4BC) Forum (PHA0071)

64 The Hepatitis C Trust (PHA0037)

65 The Migraine Trust (PHA0032)

66 The Pharmacists Cooperative (PHA0047)

67 The Pharmacists' Defence Association (PDA) (PHA0074)

68 The Pharmacists' Defence Association (PDA) (PHA0046)

69 University Hospitals of Leicester NHS Trust (PHA0031)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2023–24

Number	Title	Reference
1st	Prevention in health and social care: healthy places	HC 484
2nd	Assisted Dying/Assisted Suicide	HC 321
1st Special	NHS Dentistry: Government Response to the Committee's Ninth Report of Session 2022–23	HC 415
2nd Special	Expert Panel: Evaluation of the Government's progress on meeting patient safety recommendations	HC 362
3rd Special	Assisted Dying/Assisted Suicide: Government Response to the Committee's Second Report of Session 2023–24	HC 744
4th Special	Prevention in health and social care: Healthy places: Government Response to the Committee's First Report	HC 745

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
2nd	The impact of body image on mental and physical health	HC 114
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
4th	The future of general practice	HC 113
5th	Pre-appointment hearing with the Government's preferred candidate for the role of Chair of HSSIB	HC 843
6th	Follow-up on the IMMDS report and the Government's response	HC 689
7th	Integrated Care Systems: autonomy and accountability	HC 587
8th	Digital transformation in the NHS	HC 223
9th	NHS Dentistry	HC 964
10th	Prevention in health and social care: vaccination	HC 1764
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346

Number	Title	Reference
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112
4th Special	Evaluation of Government commitments made on the digitisation of the NHS	HC 780
5th Special	Government Response to the Committee's Report on Follow-up on the IMMDS report and the Government's response	HC 1286
6th Special	Government Response to the Committee's Report on Workforce: recruitment, training and retention in health and social care	HC 1289
7th Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce: Government Response	HC 1290
8th Special	Government Response to the Health and Social Care Committee's Expert Panel: evaluation of Government's commitments made on the digitisation of the NHS	HC 1313
9th Special	The future of general practice: Government Response to the Committee's Fourth Report	HC 1751
10th Special	Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England	HC 1310
11th Special	Digital transformation in the NHS: Government Response to the Committee's Eighth Report	HC 1803
12th Special	Government Response to the Committee's Report on Prevention in Health and Social Care: vaccination	HC 1891
13th Special	Government Response to the Health and Social Care Committee's Expert Panel: Evaluation of Government's commitments in the area of the pharmacy in England	HC 1892

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599

Number	Title	Reference
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311