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Public Services Committee

4th Report of Session 2022–23

Homecare medicines services: an opportunity lost

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Public Services Committee

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See Appendix 1.

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Evidence is published online at https://committees.parliament.uk/work/7739/homecare-medicines-services/publications/ and available for inspection at the Parliamentary Archives (020 7219 3074).

Q in footnotes refers to a question in oral evidence.

SUMMARY

Half a million people with chronic conditions in England depend upon medicines which, along with any necessary help to administer them, are delivered to their homes. These types of services are called 'homecare medicines services' and replace care that would previously have been supplied in hospital. They are mainly provided by private, for-profit, companies, to NHS patients.

We found very little understanding or consensus on anything in this sector. No one—not the Government, not NHS England, not patient groups, not regulators—knows how often, nor how seriously patients suffer harm from service failures in homecare. This indicates a significant failure of oversight and hinders the ability of NHS England to ensure patient safety. Evidence on key points—including, alarmingly, the amount of public money spent on the sector—was contradictory. The Government does not know how much money is spent on homecare medicines services. It is therefore impossible to make any assessment on value for money. Given that the figure is most likely several billion pounds per year, this lack of awareness is shocking and entirely unacceptable.

Our report acknowledges the potential of homecare medicines services—they could improve care for patients and reduce pressure on the NHS. This significant potential is not being met.

There are serious problems with the way services are provided. Some patients are experiencing delays, receiving the wrong medicine, or not being taught how to administer their medicine. Where this happens, it is no small inconvenience—it can have serious impacts on patients' health, sometimes requiring hospital care. This leaves NHS staff either firefighting the problems caused by problems in homecare medicine services, or working on the assumption that those services will fail.

In some cases, the taxpayer is effectively paying for the service twice—once for the private provider to deliver it, and again for the NHS to pick up the pieces where private providers fail.

We identified several areas where improvements were needed. In this report we deal with them in turn. We found:

- a lack of transparency; (chapter 3)
- failures in procurement; (chapter 4)
- reluctance to enforce standards; (chapter 5) and
- a difficult market with poor digital infrastructure (chapter 6).

Improvements can and must be made in some areas quickly. We have made recommendations which, if implemented, would help secure clearer, more effective services.

Most concerningly, we found a complete lack of ownership of these key services. Our final two chapters deal with the fact that no one person or organisation was willing to take responsibility for driving improvements or exploiting the full potential of homecare medicines services to bring care closer to home. Simply put, no one has a grip on this. We therefore recommend that a named individual

be appointed and appropriately supported to lead and take responsibility for homecare medicines services.

Our final recommendation is for a full-scale independent review tasked with finding answers to the more embedded structural problems. This review is essential, but it must not be allowed to delay progress where it can be made more quickly.

We were heartened to learn of substantial progress since we launched this inquiry. An NHS England review is underway. Its first task is to establish the facts. There has also been a commitment to publish performance data. Discussions with the department on system ownership have also been promising. We hope this report will be of assistance to NHS England and the Department of Health and Social Care as they continue this work.

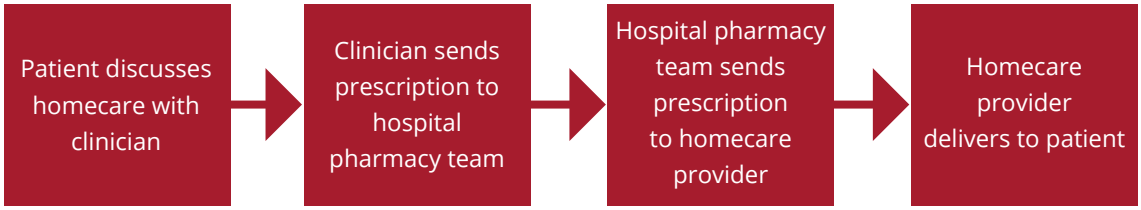
Homecare medicines services: an opportunity lost

CHAPTER 1: INTRODUCTION

What are homecare medicines services?

1. Homecare medicines services (referred to as homecare in this report) deliver medicines and assist patients to administer them in their homes, rather than in hospitals. They are specialised medical services—drugs may need to be delivered at a certain temperature or they may be difficult to administer. Homecare staff sometimes attend patients' homes to administer medicines, to teach patients how to administer to themselves or to remove ancillary items such as sharps bins.

Figure 1: Homecare from hospital to patient



2. Homecare can be suitable for a wide range of conditions and treatments, so there are many considerations when determining whether a patient is suitable to receive homecare. In most cases, patients will discuss with their clinician whether homecare would be helpful. Once the decision to proceed with homecare is made, the NHS will pass the patient's prescriptions to a private homecare company (a 'provider'). The provider will then arrange to deliver the medicines and any associated care to the patient in their home.

3. We were told that homecare had "potential to transform the lives of patients",[1] and that it has great potential as a way to alleviate pressure on hospitals.[2] When it works, it was described as "fantastic for patients".[3] Dr Christian Selinger, a Consultant Gastroenterologist and Chair of the Inflammatory Bowel Disease section of the British Society for Gastroenterology, told us that homecare "is a wonderful model for the patient because they do not have to spend as much time on it and they are much more independent. It also saves the environment because there is no travel and all that involved. When it works it works really well".[4]

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1 Written evidence from Lloyds Pharmacy Clinical Homecare (HMS0022)

2 NHS, *The NHS long term plan* (January 2019), paras 1.25, 1.47, 3.35 and 3.44: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [accessed 12 September 2023]. Written evidence from Taskforce for Lung Health (HMS0005). See also Lord Carter of Coles, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations* (February 2016), p 34: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 12 September 2023]

3 Q 2 (Ruth Wakeman). See also Q 33 (Sarah Billington) and written evidence from Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008).

4 Q 2 (Dr Christian Selinger)

4. Despite this potential, key Government policy documents such as the NHS Long Term Plan and the NHS Long Term Workforce Plan make no reference to homecare.[5] We have been unable to find any thorough explanation of how the system functions.

5. **Homecare medicines services have significant potential to deliver high-quality care to patients in their homes and reduce pressure on hospitals. They should be a key part of future planning and resourcing for the NHS.**

Models of delivery

6. Around 500,000 patients receive homecare services in England. There are around 2.85 million deliveries per year.[6]

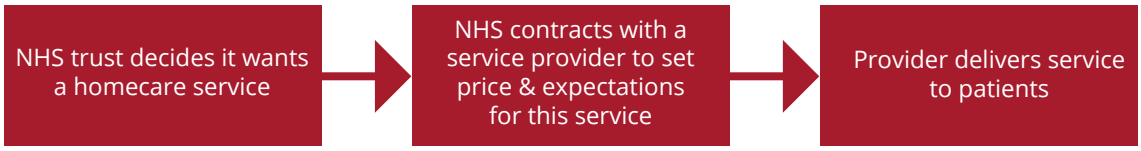
7. Since 2011, the sector has grown by 150%.[7] The number of active patients has grown 10% per year over the past 15 years. During the COVID-19 pandemic the use of homecare increased dramatically. In 2020 the number of active patients increased by 15%, and by 17% in 2021.[8]

8. Health is a devolved matter, so there are separate systems of homecare in Wales, Scotland and Northern Ireland. This report therefore primarily concerns homecare in England. Our inquiry has, however, taken note of a review underway in Scotland, which has a similar system and which has identified many of the same problems we have encountered in England.[9] The report's conclusions and recommendations may therefore be of interest to homecare services across the United Kingdom.

9. On the whole, homecare services are delivered by a private provider. There are, broadly, three models of delivery:

   (a) NHS-funded homecare is where an NHS trust contracts directly with a private homecare provider to deliver services to their patients. The NHS trust pays for the medicine and the homecare service. This model accounts for around 20% of the homecare market.

Figure 2: NHS-funded homecare



   (b) Manufacturer-funded homecare (sometimes called 'pharma-funded homecare') is where an NHS trust purchases a drug from a drug manufacturer. That manufacturer may offer, or be asked to offer, a

5 NHS, *The NHS long term plan* (January 2019): https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [accessed 11 October 2023] and NHS England, *NHS Long Term Workforce Plan* (30 June 2023): https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ [accessed 11 October 2023]

6 Supplementary written evidence from National Clinical Homecare Association (HMS0012)

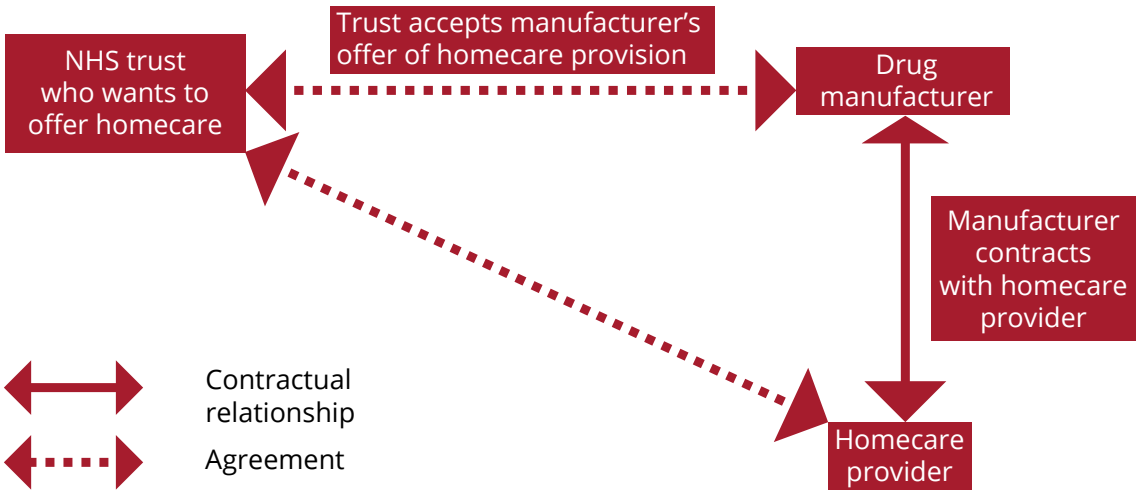
7 Q 2 (Sarah Campbell)

8 Q 17 (Alison Davis). See also written evidence from Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008), Q 2 (Sarah Campbell), Q 13 (Dr Christian Selinger), Q 33 (Sarah Billington), Q 39 (Joe Bassett) and Written Answer HL9491, Session 2022–23.

9 For further information on this review see written evidence from Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008)

homecare service. The manufacturer will then, separate from the NHS, contract with a third-party homecare provider to deliver the service to the patient. The NHS pays the drug manufacturer for the medicine, the cost of the homecare service is included. The manufacturer then pays the homecare provider separately. This means that the NHS has no direct contractual relationship with the homecare provider treating the patient, although there is usually a service level agreement between the NHS trust and the provider. This model represents around 80% of the market.

Figure 3: Manufacturer-funded homecare arrangements



(c) Private health companies can provide homecare to their patients. This constitutes a small percentage of overall services and does not draw on public funds or the NHS. We therefore do not focus on this model.

10. Those in leadership roles in the homecare sector unanimously acknowledged that the system is complex. The Minister for Health and Secondary Care, Will Quince MP, stated: "It is certainly complicated. That is an understatement."[10] David Webb, the Chief Pharmaceutical Officer for England, told us that our inquiry had unearthed a "complicated picture that is quite hard to understand even when you are working in the area."[11] Joe Bassett, the Chair of the National Homecare Medicines Committee (see table 1), said "even from the inside there are multiple cogs moving around."[12] Dr Rick Greville, a Director at the Association of the British Pharmaceutical Industry, the trade body for drug manufacturers, referred to "the complexity, governance and due diligence required of multiple individual and organisational stakeholders to establish, let alone deliver effective and efficient homecare services."[13]

11. Other witnesses stated that the "excessive level of complexity" made the system difficult for patients to navigate.[14]

10 Q 55 (Will Quince MP)
11 Q 39 (David Webb)
12 Q 48 (Joe Bassett)
13 Supplementary written evidence from Association of the British Pharmaceutical Industry (HMS0009)
14 Written evidence from British Society of Rheumatology (HMS0001). See also written evidence from Crohn's & Colitis UK (HMS0004), Phil White (HMS0016) and Q 33 (Sarah Billington).

12. **The homecare sector is highly complex, to the extent that even people working at senior levels find it difficult to understand. This is entirely unacceptable and indicates an urgent need for review and simplification.**

Other work

2011 Hackett review

13. An independent review of homecare medicine supply commissioned by the then Department of Health was published in 2011. This report, *Homecare Medicines: Towards a Vision for the Future*, identified several value-for-money issues and made recommendations on improved governance arrangements for the delivery of homecare services.[15] Several of these, for example the recommendation that the trust Chief Pharmacists should be the responsible officer for services, and the call for a set of professional standards to be developed, have been implemented. The Government's policy paper following the review primarily focused on how providers and commissioners could "work together to achieve significant savings".[16]

NHS England research

14. We heard from NHS witnesses that "work is currently under way … to better understand all the issues currently impacting on homecare".[17] There are two phases to this.

    (1) The first stage to "fully inform [the NHS'] understanding of the issues impacting homecare medicines" involves "a desktop exercise" and conversations with stakeholders. NHS England "expect this stage to complete by the autumn".

    (2) The second stage is "consideration of what potential actions are needed", including who should take actions forward, how and "the resource implications." NSH England stated that until the first stage was completed: "it is not possible to confirm the timeline or what the product of the work will be." The Minister for Health and Secondary Care, Will Quince MP, was similarly unable to give a hard timeline for this work,[18] stating "it will not take very long".[19]

15. This work falls short of the "full scale national review" called for by organisations such as the British Society of Rheumatology[20] and is narrower in scope than a review taking place in Scotland, which is due to finish in December 2023.[21] The Minister stated that, there were things that "without needing to see the paper-based exercise, I know we need to get on with and

15 Department for Health, *Homecare Medicines: Towards a Vision for the Future* (30 November 2011): https://assets.publishing.service.gov.uk/media/5a7c56d1e5274a2041cf359d/111201-Homecare-Medicines-Towards-a-Vision-for-the-Future2.pdf [accessed 11 October 2023]

16 Department of Health, *Achieving savings from high cost drugs* (29 November 2012): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213111/high-cost-drugs.pdf [accessed 11 September 2023]

17 Supplementary written evidence from Claire Foreman and David Webb, NHS England (HMS0015), Q 39 (David Webb) and Q 47 (Claire Foreman)

18 Q 59 (Will Quince MP)

19 Q 55 (Will Quince MP)

20 Q 9 (Sarah Campbell)

21 Written evidence from Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008)

do. Nevertheless, a lot more has been brought up. You can jump at these things, but it is more important to take a little bit of time to get it right".[22]

16. **While we welcome the current work on homecare medicines services, we are concerned that it is vague, lacks specific commitments, and has no clear leadership. Serious problems in homecare have been apparent for over a decade. It is now time for urgent action. Consideration of resource implications must acknowledge future savings resulting from increased efficiency and value for money in a reformed system.**

17. ***The Department of Health and Social Care should, by December 2023, make a ministerial statement on the findings and proposed actions for NHS England's work on homecare. A further statement should be provided by March 2024 on progress on these actions.***

Governance bodies

18. We took evidence from and about several relevant organisations in the sector, including governance bodies. For clarity, we have identified them in the table below.

Table 1: Relevant bodies within homecare

Name of body	Role
Oversight and regulatory bodies	
National Homecare Medicines Committee (NHMC)	The National Homecare Medicines Committee acts as "the national focus for developing and improving administration and governance processes for medicine homecare services".[23] It includes representation from NHS England, homecare providers, pharmaceutical manufacturing associations and the Care Quality Commission.
Care Quality Commission (CQC)	The Care Quality Commission, a public body, is the independent regulator of health and social care in England. It monitors, inspects and regulates services performing regulated activities under the Health and Social Care Act 2008.
Medicines and Healthcare products Regulatory Agency (MHRA)	The Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components in the United Kingdom.
General Pharmaceutical Council (GPhC)	The General Pharmaceutical Council is the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in the United Kingdom.

22 Q 55 (Will Quince MP)

23 Specialist Pharmacy Service, 'National Homecare Medicines Committee (NHMC) Terms of Reference' (5 April 2018): https://www.sps.nhs.uk/articles/national-homecare-medicines-committee-nhmc-terms-of-reference/ [accessed 11 October 2023]

Name of body	Role
Other	
Association of the British Pharmaceutical Industry (ABPI)	The Association of the British Pharmaceutical Industry is a trade body for drug manufacturers.
Commercial Medicines Unit (CMU)	The Commercial Medicines Unit is an NHS England team which works on behalf of the Department of Health and Social Care and the NHS to support those who buy pharmaceuticals for hospitals across the NHS in England.[24]
Marketing Authorisation Holders (MAHs)	Individuals or companies who hold legal authorisation to sell pharmaceuticals. In homecare services, they are generally drug manufacturers who contract with homecare providers to provide a service.
National Clinical Homecare Association (NCHA)	The National Clinical Homecare Association is the trade body for homecare providers.
Regional Procurement Hubs	Regional NHS centres of procurement expertise which can assist hospital trusts to establish or manage homecare contracts.
Royal Pharmaceutical Society (RPS)	The Royal Pharmaceutical Society is the professional membership body for pharmacists and pharmacy students.

24 Department of Health and Social Care, 'Commercial Medicines Unit (CMU)' (4 March 2011): https://www.gov.uk/government/collections/commercial-medicines-unit-cmu [accessed 22 September 2023]

CHAPTER 2: THE PROBLEM

Patient experience

19. We launched this inquiry because patient groups told us that many patients experienced problems with homecare services. Crohn's & Colitis UK reported "deep, systemic and long-standing failures in homecare medicine services".[25] Respondents to a survey run by the Cystic Fibrosis Trust had "overwhelmingly negative experiences", with 87% experiencing problems with the home delivery of their medicines.[26]

20. The key problem was delays in receiving treatment. In their inspections of homecare services, the Care Quality Commission (CQC) identified mis-delivery and delays to treatment as recurring themes.[27] This is borne out by a May 2021 report into one homecare provider in which the CQC found that there had been 9,885 patients whose medicines were missed or delayed between October and December 2020. Some had suffered "avoidable harm".[28] The Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services, currently leading a review of homecare in Scotland, (a separate but similar system), stated that service issues "have led to some patients missing doses, [and] led to delays in treatment initiation."[29]

21. We received numerous reports of delays, including from the British Society for Rheumatology,[30] the Chief Pharmaceutical Officer,[31] the British Association of Dermatologists,[32] Crohn's & Colitis UK,[33] Sciensus Pharma Services (a large provider),[34] and the Parliamentary and Health Service Ombudsman.[35]

Box 1: Experiences of delays (reported between 2022 and 2023)

"In June 2022 the initial [homecare worker sent] to teach how to correctly administer the medication, did not come as rearranged. I was also assured another nurse would come two weeks later to check the technique; this never occurred."[36]

"The majority of medications do not turn up on the date and time told."[37]

25 Written evidence from Crohn's & Colitis UK (HMS0004)
26 Written evidence from Cystic Fibrosis Trust (HMS0003)
27 Supplementary written evidence from Care Quality Commission (HMS0018)
28 While this particular volume of problems were found to be the result of a new IT system, an inspection report several months later found that the service still "required improvement" on the key safety measure. See: Care Quality Commission, *Healthcare at home—Head office: inspection report* (14 May 2021): https://api.cqc.org.uk/public/v1/reports/ab248133-cba7-4563-809a-69199ce412ac?20210514000508 [accessed 12 September 2023]
29 Written evidence from Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008)
30 Q 3. See also written evidence from British Society for Rheumatology (HMS0001) and (HMS0010).
31 Q 43 (David Webb)
32 Written evidence from British Association of Dermatologists (HMS0002)
33 Written evidence from Crohn's & Colitis UK (HMS0004) and Q 3 (Ruth Wakeman)
34 Written evidence from Sciensus Pharma Services (HMS0006)
35 Written evidence from Parliamentary and Health Services Ombudsman (HMS0007)
36 Written evidence from Olivia Goldberg (HMS0024)
37 Written evidence from Cystic Fibrosis Trust (HMS0003)

> "They messed me around so much I nearly missed a few doses as they just didn't turn up when a delivery was scheduled … Items are regularly missed from my order e.g., syringes and I have to email to ensure it's included. Sometimes it is but usually it's not, so I have to purchase my own from Amazon."[38]
>
> "I no longer expect my medicines to turn up when they say it will".[39]

22. Dr Christian Selinger reported: "it frequently takes six to eight weeks, sometimes longer, between setting up the initial contact with the homecare company and a delivery happening".[40] Most agreements require ten days between receipt of prescription and delivery of medicines,[41] six to eight weeks is a significantly greater period. Dr Selinger described it as "an unacceptably long delay".[42]

23. We also heard reports of:

    - Providers delivering the wrong, faulty, or outdated medicines or devices.[43]
    - Routine or repeat prescriptions not being received by patients, with no acknowledgement from the provider that this would happen.[44]
    - Prescriptions being received by providers and then lost.[45]
    - A lack of flexibility for the patient in when they might receive their medicine and challenges organising deliveries, including where call handlers did not understand how to organise deliveries.[46]
    - Difficulties in speaking to the provider. We were told that patients "cannot get hold of anyone … it is absolutely impossible to get through".[47]

Effect on patients

24. We were told that delays in receiving the correct medicine or care can have "real consequences for the patient"[48] and "can permanently affect a patient's quality of life".[49] For certain conditions, an interruption in medication "usually leads to the symptoms flaring up and being not well controlled".[50] We heard of patients developing problems including irreparable joint damage,[51] skin and eye problems, diarrhoea, abdominal pain, strictures, fatigue, and blood or mucus in stools.[52]

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38 Written evidence from Cystic Fibrosis Trust (HMS0003)
39 *Ibid.*
40 Q 3 (Dr Christian Selinger)
41 Written evidence from Sciensus Pharma Services (HMS0006)
42 Q 3 (Dr Christian Selinger)
43 Written evidence from British Association of Dermatologists (HMS0002), Crohn's & Colitis UK (HMS0004) and British Society for Rheumatology (HMS0001)
44 Q 3 (Dr Christian Selinger), written evidence from Crohn's & Colitis UK (HMS0004), British Society for Rheumatology (HMS0001) and British Association of Dermatologists (HMS0002)
45 Q 3 (Sarah Campbell), written evidence from British Society for Rheumatology (HMS0001) and Crohn's & Colitis UK (HMS0004)
46 Written evidence from Cystic Fibrosis Trust (HMS0003)
47 Q 3 (Ruth Wakeman)
48 Q 3 (Dr Christian Selinger)
49 Written evidence from British Society for Rheumatology (HMS0001)
50 Q 2 (Dr Christian Selinger)
51 Written evidence from British Society for Rheumatology (HMS0001)
52 Written evidence from Crohn's & Colitis UK (HMS0004)

25. A delay in medication can mean that short-term medical interventions are required. These can, depending on the condition and treatment, come with side effects including osteoporosis and psychosis.[53] Dr Christian Selinger described one treatment used in this way as "an effective but very toxic treatment that does not help in the long term … a fire extinguisher, but one that is very toxic, so we try to avoid them."[54]

26. Delays in receiving medicines can lead to conditions deteriorating. Of respondents to a Crohn's & Colitis UK survey who had experienced failures in homecare medicines delivery, 12% stated they attended A&E as a result and 5% required surgery.[55]

27. We heard that delays can render some drugs ineffective and mean that a new treatment is required to manage the condition.[56] For some conditions there are limits on the number of therapies available so patients could run out of possible treatments due to repeated delays in drug delivery.[57]

Box 2: Quotes illustrating the detrimental impact of poor service (reported in 2023)

"I am regularly going without vital medicines".[58]

"Missed doses of medicine makes me have several weeks feeling much more poorly".[59]

"I've had to stay in hospital longer".[60]

"It makes me mad, frustrated, but mostly it's heartbreaking seeing my child suffering—and feeling helpless. [Homecare provider] has added so much unnecessary stress to our lives, when we were already struggling with accepting our daughter's diagnosis."[61]

28. We were told that delays and uncertainty can be very worrying and affect the quality of life of those using services. The British Society for Rheumatology told us that patients can experience anxiety and poorer well-being, and require time off from work.[62] Difficulties arranging deliveries can mean that people need to cancel social or leisure activities.[63] One respondent to the survey conducted by the Cystic Fibrosis Trust noted: "It's terrible … the times are a nightmare and missed deliveries can take ages to rearrange … it's a horrible system". Another reported that "it is a massive burden and on top of everything else we need to do and have to deal with".[64]

53 Written evidence from British Society for Rheumatology (HMS0001)
54 Q 3 (Dr Christian Selinger)
55 Written evidence from Crohn's & Colitis UK (HMS0004)
56 Q 3 (Dr Christian Selinger), written evidence from Parliamentary and Health Services Ombudsman (HMS0007) and Crohn's & Colitis UK (HMS0004)
57 See, for example Katherine A Falloon et al, 'Current Therapy in Inflammatory Bowel Disease: Why and How We Need to Change?', *European Medical Journal*, vol. 6, (2022), pp 40–49: https://www.emjreviews.com/innovations/article/current-therapy-in-inflammatory-bowel-disease-why-and-how-we-need-to-change-j080121/ [accessed 26 October 2023]
58 Written evidence from Cystic Fibrosis Trust (HMS0003)
59 *Ibid.*
60 *Ibid.*
61 Written evidence from Crohn's & Colitis UK (HMS0004)
62 Written evidence from British Society for Rheumatology (HMS0001)
63 Written evidence from Crohn's & Colitis UK (HMS0004) and Cystic Fibrosis Trust (HMS0003)
64 Written evidence from Cystic Fibrosis Trust (HMS0003)

Impact on the NHS

29. Patients who have not received their homecare services often contact their hospital or the clinicians who referred them to the service. This has a detrimental impact on NHS resources. We were told of clinical teams having to spend "hours and hours"[65] following up prescriptions and arranging to teach self-administration of care (for example, how to inject a drug). Crohn's & Colitis UK described the amount of time spent by clinical teams liaising with homecare companies as "completely unacceptable".[66] It estimates that 10% of specialist Crohn's and colitis nurses spend a day per week working on issues related to homecare services.[67] The British Society for Rheumatology told us that one clinician they are in contact with spent up to a quarter of their time on homecare-related issues.[68]

Box 3: Clinician experience (reported between 2022 and 2023)

"Huge delays in getting drugs out to patients, they promise it is within 10 working days, but this doesn't happen. Rheumatology nurses have to start all treatment in hospital now and issue an 8-week supply of medication to prevent flare of disease. Impact on nursing team and prescribing team is immense".[69]

"I have lost count of the amount of patients we have had to start on our own hospital pharmacy supplies".[70]

"Patients should be supported by [homecare provider] as per service level agreement, but they end up calling our advice lines because nobody answers their calls."[71]

30. The British Society for Rheumatology reported hospital teams being "forced to take steps to proactively manage issues before they happen."[72] They told us that some hospitals, aware that there were problems, protected patients by issuing treatments, teaching self-administration and arranging their own delivery services. They were clear that "anticipating shortfalls and implementing workarounds is neither best practice nor an optimum use of resources, especially when it comes at additional financial and staff costs to the NHS."[73] Though it is difficult to quantify the cost of these workarounds, activities such as running clinics, or providing advice or assistance via telephone require staff time which could be spent elsewhere. Dr Christian Selinger spoke about an infusion unit in Leeds, which taught patients to self-administer medicine, and provided this analysis:

> "We are doing something that the homecare company is paid for but cannot deliver. That has consequences because those specialist nurses are not available to deal with other patients. Similar things happen in other units. Either patients suffer or the NHS does mitigation, which has consequences as well."[74]

65 Q 3 (Dr Christian Selinger)
66 Written evidence from Crohn's & Colitis UK (HMS0004)
67 Q 3 (Ruth Wakeman)
68 Written evidence from British Society for Rheumatology (HMS0001)
69 *Ibid.*
70 *Ibid.*
71 Written evidence from Crohn's & Colitis UK (HMS0004)
72 Written evidence from British Society for Rheumatology (HMS0001)
73 *Ibid.*
74 Q 3 (Dr Christian Selinger). See also written evidence from British Society for Rheumatology (HMS0001).

31. In some cases, a patient may have to be hospitalised because their medicines have been delayed. This is, as Dr Selinger points out, "awful for the patient, but it is also an absolute waste of NHS resources".[75]

32. **Delays in providing homecare services can negatively impact on patients physical and mental health. For some, impacts can be serious safety issues and include patients being admitted to hospital or requiring surgery.**

33. **In some cases the failure of provision of homecare medicines is so severe, or so predictable, that NHS services are compelled to use their resources for services which should be delivered by homecare providers. The NHS can pay twice—once for the homecare provider and, when that fails, to provide the service themselves.**

75 Q 3 (Dr Christian Selinger)

CHAPTER 3: TRANSPARENCY

The scale of the problem: competing views

34. Will Quince MP, the Minister for Health and Secondary Care, noted that "the evidence presented to the Committee is conflicting and mixed".[76] The evidence on the scale of the problems in homecare medicines services fell into two categories. Patient groups and clinical representatives told us that the problems with homecare were extensive and long-lasting.[77] By contrast, providers, regulators and industry bodies, while they recognised that on occasion there had been problems, told us that these problems were small in scale. Claire Bryce-Smith, Director of Insight, Intelligence and Inspection at the General Pharmaceutical Council, said that "from our perspective, it is a model that is performing quite well overall".[78]

35. Alison Davis, Chair of the National Clinical Homecare Association, noted this "disparity between the reports of the patient groups and medical societies and those of homecare providers and their regulators."[79] Claire Bryce-Smith found it "perplexing".[80]

Table 2: Quotes illustrating competing views

Subject	Providers and oversight bodies	Patient groups and clinical representatives
Control over health outcomes	"We empower our patients to have better control of their health through knowledge, choice, convenience, and connection".[81]	Delays have "resulted in flares and less well controlled disease amongst those patients affected, increased anxiety, and an increased use of steroids".[82]
Performance of the sector	"It is a model that is performing quite well overall. There are only a few that have not performed well."[83]	"There are deep, systemic and long-standing failures in homecare medicines services, which go beyond issues experienced by just one provider."[84]
Urgency of medicines	"These patients are not acute patients. They are chronic patients."[85]	Relapses caused by running out of medicine "can have a profound and devastating impact on all aspects of a person's life".[86]

76 Q 55 (Will Quince MP)
77 See for example written evidence from Crohn's & Colitis UK (HMS0004).
78 Q 25 (Claire Bryce-Smith)
79 Supplementary written evidence from National Clinical Homecare Association (HMS0012)
80 Q 37 (Claire Bryce-Smith)
81 Written evidence from Sciensus Pharma Services (HMS0006)
82 Written evidence from British Society for Rheumatology (HMS0001)
83 Q 25 (Claire Bryce-Smith)
84 Written evidence from Crohn's & Colitis UK (HMS0004)
85 Q 27 (Sarah Billington)
86 Written evidence from Crohn's & Colitis UK (HMS0004)

Subject	Providers and oversight bodies	Patient groups and clinical representatives
Patient safety	"Fundamentally, it is my view that homecare medicines services are safe, and they are valued by patients."[87]	"As a doctor [and patient] and with family to help advocate on my behalf, if I have struggled to navigate the system over the last year, I imagine many other patients have experienced similar frustrations and likely come to harm".[88]

36. We considered whether, as several witnesses suggested, the disparity might reflect a high number of people receiving healthcare—a small percentage of a sizeable cohort of patients would represent a lot of people but would not necessarily indicate a systemic failure of the industry as a whole.[89] Evidence from the industry body, the National Clinical Homecare Association, demonstrates that in 2020 there were 58,640 patient safety incidents,[90] representing 13.7% of active patients. This had fallen by 2022, to 6.8% still a substantial percentage. It is fair to note that 'patient safety incident' encompasses a broad range of events, such as the administration of incorrect medicine, safeguarding issues, or aggressive behaviour towards clinical staff. A patient safety incident does not necessarily indicate fault on the part of any single actor.[91]

37. We were told that, for the four largest homecare providers, satisfaction surveys had shown between 86% and 99% of respondents rated the overall experience as "good" or "very good".[92] Contrasting with that is the evidence of patient groups such as the Cystic Fibrosis Trust, who told us that 87% of respondents to a survey experienced problems with the home delivery of medicines.[93]

38. Some of the data we were provided with was described as "cherry picked".[94] The National Clinical Homecare Association, the trade body for homecare providers, told us: "in 2022, 98.8% of deliveries were delivered on the day they were intended to be delivered on."[95] The 98.8% figure seemed to be "phenomenally good".[96] However, it reflects success against the date that the homecare provider planned to deliver the medicines. It does not reflect the day that the prescribing clinician had intended the patient to take the medication.[97] The date the provider intends to deliver the medicines would

87 Q 39 (Joe Bassett)
88 Written evidence from Olivia Goldberg (HMS0024)
89 Q 36 (Sarah Billington), written supplementary evidence from National Clinical Homecare Association (HMS0012)
90 A patient safety incident is defined by the NHS as "any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare." NHS England, *Report a patient safety incident:* https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/ [accessed 11 October 2023]
91 NHS England, *Report a patient safety incident:* https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/ [accessed 24 October 2023]. See also written evidence from the National Clinical Homecare Association (HMS0012)
92 Q 39 (Joe Bassett). These had a sample size of 23,000 patients.
93 Written evidence from Cystic Fibrosis Trust (HMS0003)
94 Supplementary written evidence from British Society for Rheumatology (HMS0010)
95 Q 20 (Alison Davis)
96 Q 23 (Dr Rick Greville)
97 Supplementary written evidence from National Clinical Homecare Association (HMS0012)

be set at a late stage in the process, so success against this date does not reflect any time taken for the prescription to leave a hospital pharmacy; nor any time before it is processed by the homecare provider. This was described to us as a "vitally important distinction".[98] Delays and failures can happen before the provider appoints a day for delivery so this statistic is only a small part of the picture, and provides a false impression of the performance of homecare services.

39. **There is an irreconcilable gulf between the views of clinicians and service users, and that of the leadership and governance bodies in the homecare sector on how well it is performing. While this is a complicated system with multiple variables, we are persuaded by the weight of evidence from service users that there are real and serious problems in the sector.**

Performance data

40. Performance data would provide answers on the extent of any problems with homecare. Such data is collected. There are 27 key performance indicators (KPIs) developed by the National Homecare Medicines Committee and published by the Royal Pharmaceutical Society. These include the number of failed deliveries (broken down into various categories), delayed clinical services, formal complaints or incidents opened, and adverse drug event incidents.[99] Homecare providers collect this information every month and report it to the NHS.

41. However, the performance data is not published by the NHS. This inhibits public scrutiny and makes it "difficult to get a clear picture of the reliability and safety of services provided".[100]

42. The data is not proactively made available to the clinicians who arrange homecare for patients. This could prevent clinicians from making informed choices when discussing the option of homecare with patients: "You cannot look and see that one company delivers on its performance a lot better than the others."[101]

43. The effect of poor performance on patients is unknown. Some may be slightly inconvenienced, whereas others may become unwell, even requiring surgery. It is possible that some may die. Neither the Government nor the regulators could provide data on how far patients suffered harm as a result of any failures in homecare.[102] Joe Bassett, Chair of the National Homecare Medicines Committee, explained that it was possible for the parties who have access to the data to capture some information on harms, but this would require analysis.[103]

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98 Supplementary written evidence from British Society for Rheumatology (HMS0010)

99 NHS England, *Homecare Medicines and Services Key Performance Indicators:* https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.rpharms.com%2FPortals%2F0%2FRPS%2520document%2520library%2FOpen%2520access%2FV6.2%2520-%2520Homecare%2520Medicines%2520and%2520Services%2520KPIs_final%2520for%2520RPS.xlsx [accessed 11 October 2023] The Department for Health and Social Care have clarified that there are 27 KPIs. Several pieces of evidence refer to 61 KPIs. This arises from a misunderstanding of the spreadsheet: there were previously 61 rows in the relevant tab in the spreadsheet ('KPI definition'), of which 34 were data definition entries.

100 Written evidence from British Society for Rheumatology (HMS0001)

101 Q 4 (Dr Christian Selinger)

102 Written Answer HL9574, Session 2022–23 and Q 26 (Sarah Billington, Claire Bryce-Smith)

103 Q 43 (Joe Bassett)

44. **No one—not the Government, not NHS England, not patient groups, not regulators, knows how often, nor how seriously patients suffer harm from service failures in homecare. This indicates a significant failure of oversight and hinders the ability of NHS England to ensure patient safety.**

45. ***NHS England must identify how many patients have become unwell or have been harmed because of a failure in homecare services. They should ensure that this information is published and shared with relevant parties. It should also form part of the ministerial statements we have requested by December 2023 and March 2024.***

46. In both manufacturer-funded and NHS-funded homecare arrangements the key forum for monitoring performance is regular meetings between the NHS trust and the provider. This, the providers body told us, allowed the NHS to monitor performance against a service level agreement.[104]

47. In addition to NHS staff, Marketing Authorisation Holders have responsibilities for ensuring the quality of services. The Association of the British Pharmaceutical Industry, who represent manufacturers, told us that their organisation, "manage[s] and fund[s] homecare service contract with HcP (the homecare provider)", and that this includes "monitoring of KPIs, as contracted".[105]

48. It is unclear whether this means monitoring KPIs as set nationally and which apply to the relationship between the NHS and the provider, or separate KPIs contracted between the manufacturer and the provider. KPIs between manufacturers and providers have no standard template and can differ substantially based on the contractual arrangements. Sciensus, a large provider, explained the different sets of performance indicators:

> "For a single medicine service there will be the standard … KPIs that have to be reported to the NHMC [National Homecare Medicines Committee]. There will also be a set of KPIs required by the Market Authorisation Holder/pharma company if they are funding the service. Although there will be similarities, each pharma company may require different KPIs."[106]

49. In manufacturer-funded homecare, NHS trusts do not have sight of the contracts, the KPIs they set out or performance data against them. Sciensus described this as a challenge for homecare services and called for a "more robust programme of standardisation and an agreed set of core KPIs that can then be aggregated and published for benchmarking."[107]

50. Similarly, while there is a national set of KPIs for which the criteria are published, performance against these indicators is not available to Marketing Authorisation Holders. The manufacturers know what these KPIs are but do not see the performance data against them though, as mentioned in chapter 4, they would wish to.[108]

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104 Supplementary written evidence from National Clinical Homecare Association (HMS0012)
105 Supplementary written evidence from Association of the British Pharmaceutical Industry (HMS0009)
106 Supplementary written evidence from Sciensus Pharma Services (HMS0017)
107 Written evidence from Sciensus Pharma Services(HMS0006)
108 Q 17 (Dr Rick Greville)

51. Sarah Campbell, Chief Executive at the British Society for Rheumatology, noted a substantial divergence in performance indicators: "different people are being held to different standards, measures and indicators … they are not singing from the same hymn sheet."[109]

52. **Different sets of performance data are available to manufacturers and the NHS. This creates confusion and prevents effective monitoring.**

53. ***NHS England must develop and implement one consistent set of performance metrics.***

Publication

54. In evidence to our inquiry NHS England representatives announced that they would review the data points collected.[110] We later heard that this may include a greater focus on patient experience.[111] The national collation would then be published.[112] Publication of performance against these KPIs would follow, by April 2024.[113]

55. Joe Bassett told us that there would be "consideration of specific details of the published report" and gave some examples of what they would consider publishing, including "frequency, granularity, validation methodology".[114] In evidence given subsequently, the Chief Pharmaceutical Officer for England David Webb told us that "it is on those new KPIs that we will attempt to publish the national collation".[115] Consultation on these new KPIs began in September 2023.[116]

56. At present, the data on performance against key performance indicators is self-reported. As the British Society for Rheumatology drew to our attention, it is not independently verified.[117]

57. **Publication of performance data and greater inclusion of patient perspectives in that data are welcome. However, there is a risk that the performance data could be published in such a diluted form that it becomes meaningless. How frequently the data is published, how detailed it is and whether the data is validated will matter hugely.**

58. ***The Chief Pharmaceutical Officer for England should ensure that the KPI data is published in a consistent, standardised form which is sufficiently specific and regular to ensure meaningful public scrutiny.***

109 Q 10 (Sarah Campbell)
110 Q 40
111 QQ 53, 55 (David Webb)
112 Q 40
113 Supplementary written evidence from Claire Foreman and David Webb (HMS0015)
114 Supplementary written evidence from National Homecare Medicines Committee (HMS0014)
115 Q 53 (David Webb)
116 QQ 53, 55 (David Webb)
117 Written evidence from British Society for Rheumatology (HMS0001) and (HMS0010)

CHAPTER 4: PURCHASING

59. We were given diverging figures for the amount spent on homecare medicines services. Alison Davis, Chair of the National Clinical Homecare Association, stated that "Some £4.1 billion of Treasury money is spent on these services per annum".[118] The Government were unable to provide an independent, verified figure—they relied on reports from the National Clinical Homecare Association, however, the figure that the Government quoted from the National Clinical Homecare Association was £3.2 billion.[119] This is almost £1 billion less than the figure the same organisation reported to us. We asked the Minister to clarify. He later wrote to us, supplying a third figure:

> "According to data that NHS England has access to, the reported spend on homecare medicines for England for the year from September 2022 to August 2023 is c.£2.9bn. This is data for England only based on collated monthly trust data for medicines issues to patients receiving homecare. Figures provided by NCHA may differ as they are based on UK data and include private sector spend. For NHS-funded homecare medicines services, along with the costs of medicines, additional costs could be included for: delivery, clinical waste collection, ancillaries, training of patients and ongoing nursing. For pharma funded schemes these costs are picked up by the companies and are unknown to the NHS due to commercial sensitivities."[120]

As the Minister acknowledges, there are additional costs for NHS-funded homecare (including delivery, and any required care or help to administer it). This figure is not, therefore, the whole picture. Moreover, the cost information collected from trusts is collated for all patients receiving homecare, so there is no possibility of comparing how cost-effective different providers may be, nor whether NHS-funded or manufacturer-funded homecare is better value for money.

60. **The Government does not know how much money is spent on homecare medicines services. It is therefore impossible to make any assessment on value for money. Given that the figure is most likely several billion pounds per year, this lack of awareness is shocking and entirely unacceptable.**

61. ***The Government must clarify exactly how much public money is spent on homecare medicines services.***

62. Despite the (disputed but substantial) cost to the Treasury, witnesses told us that there was extremely limited support for procurement.

Available support

63. We were told that "there is a huge amount of effort involved in managing [homecare] contracts and being aware of the impact on your patients".[121] As explained by the Chief Pharmaceutical Officer for England David Webb, this requires specialist knowledge. He told us that effective contract management

118 Q 20 (Alison Davis)
119 Q 50 (Will Quince MP). See also Written Answer HL9385, Session 2022–23.
120 Supplementary written evidence from the Department of Health and Social Care (HMS0026)
121 Q 39 (David Webb)

"calls for a significant understanding of how the contracts operate and the risks".[122]

64. For NHS-funded homecare, NHS England's Commercial Medicines Unit and regional procurement hubs provide some support to trusts. The Commercial Medicines Unit oversees frameworks for four specific clinical areas, allowing "trusts to draw off that and therefore supply their patients".[123] These frameworks allow for provision of only around 4% of total homecare provision.[124] There are also regional procurement hubs to support trusts in arranging NHS-funded homecare. They set regional framework agreements for NHS-commissioned homecare services. An NHS trust can seek a supplier identified in these framework agreements, though they are not limited to the providers identified in them.[125]

65. The majority of homecare is manufacturer funded. Neither the Commercial Medicines Unit nor NHS procurement hubs support trusts with manufacturer-funded homecare. These contracts are "directly arranged" and "locally established".[126] Service level agreements between the trust and the provider set out expected performance, but this is separate from the contractual relationship.

Lack of expertise

66. Within procurement hubs, which support NHS trusts when they contract with providers, there is not always a homecare specialist. We were told that "funding is variable for those posts".[127]

67. Manufacturer-funded homecare is usually arranged between the trust and the drug manufacturer without the involvement of a regional hub.[128] We were told that trusts have insufficient staff to support these arrangements. Alison Davis linked this to funding: "Fundamentally, there is a lack of funding in the NHS for homecare teams … many hospitals remain without dedicated or sufficient staff to manage these services internally."[129]

68. Such provision and expertise fluctuates between trusts. Richard Bateman, member of the Royal Pharmaceutical Society Hospital Expert Advisory Group, described a "significant variation in funding and resourcing of pharmacy homecare teams between trusts and the mechanisms for funding those teams".[130]

Information

69. This section will largely concentrate on information on the performance of providers. We note, however, that given the need (discussed in paragraphs 30–32) for hospitals sometimes to provide services themselves, information on cost, and cost effectiveness, would be useful to front-line clinicians. Unfortunately, such information is not available.

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122 *Ibid.*
123 Q 39 (Claire Foreman)
124 *Ibid.*
125 Q 44 (Joe Bassett)
126 Q 39 (Joe Bassett)
127 Q 44 (Joe Bassett)
128 Q 39 (Joe Bassett)
129 Q 17 (Alison Davis)
130 Supplementary written evidence from Royal Pharmaceutical Society (HMS0013), Q 21 (Richard Bateman), Q 18 and Q 39 (David Webb)

70. On a basic level, staff arranging contracts and monitoring agreements with homecare providers could be expected to know how the provider has performed. This would enable them to make informed decisions.

71. For NHS-funded homecare, such knowledge would usually be in procurement hubs, who "get the collective data for all the hospitals".[131] The performance data is also reported to individual hospitals.[132] However, this data is not necessarily passed to clinicians who decide whether a patient should receive homecare.[133]

72. Marketing Authorisation Holders work for drug manufacturing companies. They are responsible for procuring the homecare services delivered to NHS patients under manufacturer-funded arrangements. Dr Rick Greville, a Director of the Association of the British Pharmaceutical Industry, stated that while Marketing Authorisation Holders "have good insight into the intended design of the service", "very often the feedback mechanism or the transparency in how successfully that service is being operated as a day-by-day function is sometimes missing … they would prefer greater transparency in the data".[134]

73. **Though there is substantial variation, in many cases, those procuring and recommending homecare services appear ill-equipped to do so. In some cases, expertise is missing; in others, there is insufficient information. Given this, and the clear commercial incentives for manufacturers to choose cheaper provision, there can be no reliable assurance that a provider is suitable before agreements are made.**

74. **Given the substantial public cost of homecare medicines, improving procurement processes should be an urgent priority. In their current form, neither the National Homecare Medicines Committee nor regional procurement hubs are equipped to lead the change required.**

75. ***The review must outline necessary steps towards establishing a central resource of experienced procurement professionals to assist in establishing homecare medicines services. This must be available to all those establishing agreements, whether they are manufacturer- or NHS-funded.***

131 Q 22 (Alison Davis)
132 *Ibid.*
133 Q 11 (Dr Christian Selinger)
134 Q 17 (Dr Rick Greville)

CHAPTER 5: REGULATORS

Structure

76. There is no one regulator for homecare services.[135] The CQC and the General Pharmaceutical Council each regulate different activities within homecare provision. Also relevant are the Medicines and Healthcare products Regulatory Agency, and the Parliamentary and Health Services Ombudsman. We were told: "We are all looking at different aspects".[136]

77. While the General Pharmaceutical Council regulates 26 providers (all those providing pharmacy activities), the CQC regulates only ten (those providing regulated activities pursuant to the Health and Social Care Act 2008).[137] These criteria for regulation are separate from the key performance indicators mentioned in chapter 3.[138] Sarah Billington, Deputy Director of Medicines Optimisation at the CQC, acknowledged, "there is no one saying overarchingly, 'This provider is not doing this and this.'"[139] Neither the CQC nor the General Pharmaceutical Council believed, though, that there were significant gaps in regulation: "we are not overlapping, but we are all making sure there are no gaps between the work we do".[140]

78. The regulatory structure was criticised by Dr Christian Selinger, a Consultant Gastroenterologist and Chair of the Inflammatory Bowel Disease section of the British Society for Gastroenterology, for lacking an arbitrator who can make a final, binding decision. He drew comparisons with the regulation of medics:

> "If I as a doctor do something wrong, there is an ultimate arbitrator, the GMC [General Medical Council], that will hold me to account regardless of what my employer thinks. If a pharmacist does something wrong, there is the General Pharmaceutical Council. For nurses, there is the Nursing and Midwifery Council. Yet for these companies there seem to be several bodies and none of them is the ultimate arbitrator."[141]

Awareness

79. The British Society for Rheumatology argued that homecare was a "blind spot" for regulators. They reported: "we were surprised to discover that the issues were not on their radar".[142] Several elements of the CQC's evidence would seem to support claims that it lacks awareness of the homecare sector.

    (a) The CQC told us that between June 2022 and July 2023 it had conducted three homecare provider inspections.[143] Set against the concerns raised to it, this is a very small number of inspections.

135 Q 24 (Sarah Billington)
136 *Ibid.*
137 Q 24. See Health and Social Care Act 2008, Schedule 1
138 Q 3 (Sarah Campbell)
139 Q 33 (Sarah Billington)
140 Q 24 (Sarah Billington)
141 Q 4 (Dr Christian Selinger)
142 Q 3 (Sarah Campbell) and supplementary written evidence from British Society for Rheumatology (HMS0010).
143 Supplementary written evidence from Care Quality Commission (HMS0018)

(b) The CQC was unable to identify the number of complaints received about homecare services due to the way that its systems categorise care—it has no specific category for homecare services.[144]

(c) In reference to the performance of the sector, Sarah Billington repeated the figure given by the National Clinical Homecare Association which stated that 98.8% of deliveries were delivered on the day intended.[145] This, as we have pointed out in paragraph 38, was described as "cherry picked"[146] as it measures a very particular part of the process.

(d) Neither the CQC nor the General Pharmaceutical Council has conducted data collection on harms to patients arising from failures in the service.[147]

(e) The CQC does not always ask hospital providers about homecare.[148]

80. Thematic reviews are designed to look at whole systems, on the understanding that this can yield more information than individual inspections. The CQC has undertaken 14 such reviews over the last three years. While the General Pharmaceutical Council is undertaking a "short, themed review of a small sample of pharmacies … within homecare service settings",[149] the CQC has no plans to run a thematic review.[150]

Appetite for enforcement

81. Sarah Billington told us: "we are regulating individual providers and we are holding them to account. We do require them to meet the standards and we take action where they do not."[151] However, some witnesses thought that there was insufficient action taken against homecare providers. The British Society for Rheumatology described a "toothless enforcement culture",[152] and Crohn's & Colitis UK recommended "stronger enforcement … [with] financial penalties for failures in services that cause additional burden on the NHS."[153]

82. Healthcare at Home (now Sciensus) was inspected by the CQC in November 2020. The report notes that there were 9,885 patients whose medicines were missed or delayed, and that there had been "avoidable harm to some patients". The CQC issued a safety rating of "inadequate". The enforcement process was complex but culminated in placing the provider in 'special measures'. This means that the service would be inspected again within six months and, if the provider remained at inadequate for any core service, action would begin to prevent operations.[154]

144 Supplementary written evidence from Care Quality Commission (HMS0018)
145 Q 25 (Sarah Billington)
146 Supplementary written evidence from British Society for Rheumatology (HMS0010)
147 Q 26
148 Supplementary written evidence from Care Quality Commission (HMS0018)
149 Supplementary written evidence from General Pharmaceutical Council (HMS0011)
150 Q 25 (Sarah Billington) and supplementary written evidence from Care Quality Commission (HMS0018)
151 Q 25 (Sarah Billington)
152 Written evidence from British Society for Rheumatology (HMS0001)
153 Written evidence from Crohn's & Colitis UK (HMS0004)
154 Care Quality Commission, *Healthcare at home - Head office: inspection report* (14 May 2021): https://api.cqc.org.uk/public/v1/reports/ab248133-cba7-4563–809a-69199ce412ac?20210514000508 [accessed 19 September 2023]

83. The CQC initiated 87 prosecutions between April 2015 and February 2023 across the whole of their sector. This included very few prosecutions of large hospital trusts. There is a range of severity—while some cases were of avoidable deaths, rapes and life-altering injuries, one provider was prosecuted for failing to publish the most recent CQC inspection report prominently on their website.[155] We have seen no evidence of prosecutions initiated against homecare companies.

84. **The regulatory model for homecare is failing to ensure the safety and quality of patient care. The regulators appear to have a limited understanding of the sector and there appears to be no appetite to find more information. Enforcement action taken against providers, even where avoidable harm has taken place, is feeble. There appears to be no appetite to issue penalties against non-compliant homecare providers. Poor performance can go unchecked. We note the discrepancy between the approach the CQC takes towards small residential homes and that taken towards homecare medicines providers.**

85. ***The Secretary of State should review the regulatory regime for homecare medicines services, considering in particular the lack of enforcement action taken by the CQC against homecare providers where avoidable harm has occurred. The review should identify a lead regulator with the skill and the breadth necessary to take necessary action against providers which are under-performing. These urgent actions should also be reflected in the longer-term review of healthcare regulation.***

86. ***The Secretary of State for Health and Social Care should instruct the CQC to conduct a thematic review of homecare medicines services.***

155 The report took the inspector "more than 15 minutes to find". This case, resulting in a fine of £500, cost over £5,000 in court costs. See Care Quality Commission, 'List of prosecutions brought by CQC', (3 October 2023): https://www.cqc.org.uk/about-us/how-we-do-our-job/prosecutions [accessed 2 November 2023]

CHAPTER 6: STATE OF THE MARKET

87. There are a small number of homecare providers on the market. In June 2023, 26 were registered with the General Pharmaceutical Council.[156] They do not all provide all services.

88. Dr Christian Selinger believed: "there is no true competition between the companies."[157] The Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services stated that barriers to entering the market and competition in it include:

> "… requirements for a high degree of capital given the cost of the medicines concerned and incumbency advantages linked to the disruption and cost … involved in changing provider. Economies of scale are essential to the current homecare business model."[158]

89. If, as Dr Selinger suggests, this is the case in England as in Scotland, it means that, if a homecare provider is unable to deliver services to a sufficient standard, there are sometimes few, if any, alternatives for the manufacturer or the NHS body.[159]

90. Joe Bassett, Chair of the National Homecare Medicines Committee, argued that " a large volume of homecare providers … are in the market and able to provide services". He acknowledged that some providers cover a large number of patients and the manufacturer-funded services represent a "disproportionate spread … there is a tendency for those services towards specific providers and larger providers."[160] We were told that there is geographic variation in service levels offered by homecare providers, further limiting trusts' options and reducing competition.[161]

91. **There is a clear perception of a lack of robust competition in the homecare medicines market, in part caused by geographic variation of service levels, barriers to entering the market and poor procurement practices.**

92. ***As part of a review of homecare medicines services, the Government should work with procurement specialists, the National Audit Office, and the Competition and Markets Authority to identify barriers to competition and effective procurement in the homecare medicines market. They should agree actions to ensure procurement by the NHS or medicines manufacturers achieves value for money.***

Systems interoperability

93. Witnesses told us of a lack of IT interoperability between homecare services. Providers have developed different systems, with no single NHS system for providers to interact with.[162] Sciensus estimated that around 6,000 paper

156 Q 24 (Claire Bryce-Smith)
157 Q 4 (Dr Christian Selinger)
158 Written evidence from the Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008)
159 Supplementary written evidence from National Clinical Homecare Association (HMS0012)
160 Q 44 (Joe Bassett)
161 Written evidence from Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services (HMS0008)
162 Q 17 (Alison Davis, Richard Bateman)

prescriptions are written in the UK every day on more than 1,000 different templates.[163]

94. This lack of interoperability and a reliance on paper-based systems were thought to challenge streamlined and efficient services to patients, both for the providers and for clinicians in hospitals.[164] The British Society for Rheumatology wrote that it took "clinicians away from patients, and pharmacy professionals away from medicines optimisation and safety oversight."[165] This view was shared by Dr Anthony Isaacs, London North West Healthcare University Trust's Clinical Lead for Rheumatology and Clinical Chair at North West London sector Rheumatology Clinical Research Group, who reported a high volume of time it takes medical staff to complete healthcare company registration and prescriptions paper forms: "time that could be spent instead on other aspects of patient care".[166] The British Society for Rheumatology noted that it prevented tracking of patient safety and outcomes.[167]

95. Against this backdrop, witnesses were clear that moves towards digital interoperability were "crucial".[168]

96. The key request of witnesses was that these systems were designed in conjunction with homecare providers and NHS trusts. Sarah Campbell emphasised this, along with the need for "them to interoperate with NHS systems that are also currently in use."[169] There were indications that homecare providers were moving to electronic portals, but it was feared that this might "remain an inefficient process" in that portals will continue to be separate and non-integrated.[170] Dr Christian Selinger explained:

> "Having several different portals that you need to register with, having to train on how to use them and having to remember all the passwords is just going to slow the process down. If the industry could come to one standard that would work with the same IT system, that would be extremely helpful."[171]

97. Similarly, Dr Anthony Isaacs called for a "single homecare portal for use by all the homecare companies that also integrates in some way with NHS hospital systems".[172] The British Society for Rheumatology thought that "this needs to come from the NHS centrally."[173]

98. ***A single homecare portal should be created and provided by NHS England. If possible this should be linked with existing online services such as the NHS App.***

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163 Written evidence from Sciensus Pharma Services (HMS0006)
164 Written evidence from Sciensus Pharma Services (HMS0006) and Crohn's & Colitis UK (HMS004)
165 Written evidence from British Society for Rheumatology (HMS0001)
166 Written evidence from Dr Anthony Isaacs (HMS0023)
167 Written evidence from British Society for Rheumatology (HMS0001)
168 Q 20 (Alison Davis). See also supplementary written evidence from National Homecare Medicines Committee (HMS0014).
169 Q 7 Sarah Campbell
170 Written evidence from Dr Anthony Isaacs (HMS0023)
171 Q 7 (Dr Christian Selinger)
172 Written evidence from Dr Anthony Isaacs (HMS0023)
173 Written evidence from British Society for Rheumatology (HMS0001), see also Q 20 (Alison Davis).

Electronic prescribing

99. The Electronic Prescription Service is a national digital product described as the "'carrier' of a prescription message in a secure way between individual prescribing and dispensing systems".[174] Electronic prescribing was said to "increase efficiency and reduce risk … [and] … create a single patient record accessible to any part of the health system".[175]

100. Electronic Prescription Service in primary care settings is advanced—93% of GP practices use Electronic Prescription Service, with more than 67% of their prescriptions delivered in this way. The NHS Long Term Plan states: "all providers will be expected to implement electronic prescribing systems".[176] However, prescriptions which will be delivered by homecare medicines services providers are not sent from trusts to providers using Electronic Prescription Service—they are generally sent using the postal service.[177] Alison Davis was sceptical, however, of how urgently this was being addressed within secondary care. She said "NHS Digital has been working on it for more years than I care to mention. We are not there yet."[178] Similarly, Dr Selinger was clear that secondary care and homecare provision had "not really caught up" and that until five years ago fax prescriptions were required—"years after electronic prescribing for hospital inpatients had become a reality."[179]

101. The Chief Pharmaceutical Officer for England believed that secondary care would need to be able to use electronic prescription systems, and that there needed to be "emphasis on its importance so that in the priority of digital development it is sufficiently visible and resourced".[180]

102. In January 2023, the Government stated that work to move homecare medicines services to an Electronic Prescription Service was at an "advanced stage in preparation for consultation with National Homecare Medicines Committee during 2023".[181] When asked what steps the Government is taking to improve interoperability of information management systems between the NHS and homecare providers, the Government pointed to an Information Standard Notice which largely focuses on consistency of syntax.[182] Rahul Singal, Chief Pharmacy Information Offer for NHS England, stated that the notice sets "consistent terminology for what all medicines are across all systems and agree a common standard."[183] However, he acknowledged that getting NHS providers and private companies to adopt the standard presented "a broader challenge", including in how far NHS trusts enforce the use of the standard.

103. ***More urgency is required in developing Electronic Prescription Systems for homecare providers to use. These must be developed in collaboration between homecare providers and NHS trusts.***

174 Supplementary written evidence from Claire Foreman and David Webb, NHS England (HMS0015)
175 Supplementary written evidence from National Clinical Homecare Association (HMS0012)
176 NHS, *The NHS Long Term Plan* (January 2019), paras 5.4 and 6.17: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [accessed 11 October 2023]
177 Q2 (Sarah Campbell, Dr Christian Selinger) and Q 27 (Sarah Billington).
178 Q 20 (Alison Davis)
179 Q 9 (Dr Christian Selinger)
180 Q 47 (David Webb)
181 Written Answer 129963, Session 2022–2023
182 Written Answer HL9662, Session 2022–2023
183 Q 57 (Rahul Singal)

CHAPTER 7: WHO IS RESPONSIBLE?

Political ownership

104. Pharmacy-related issues such as prescription delays, electronic prescription and pharmacy management are crucial in the performance of homecare medicines services. The Minister responsible for homecare medicines services is the Minister of State for Health and Secondary Care.[184] However, pharmacy services are within a separate portfolio, that of the Minister for Primary Care and Public Health.[185] The Minister of State for Health and Secondary Care, Will Quince MP, did not think that the separation of portfolios in this area was "in any way an impediment to what we do."[186] He stressed that all Ministers spoke daily, referring to an open plan office within the Department of Health and Social Care. While we acknowledge that ministerial portfolios often overlap, we note that the separation of homecare services from pharmacy services could create confusion in accountability. As we outline in this chapter, this is in the context of an already difficult environment.

Accountability and oversight

105. Sciensus, the biggest provider in the sector, described the current system of accountability as "very complex".[187]

106. The National Homecare Medicines Committee has no "formal responsibility or accountability for homecare provision across the entirety of the NHS."[188]

107. The trust Chief Pharmacist is responsible for the quality of services provided to patients. However, when we asked David Webb who, as Chief Pharmaceutical Officer is the professional lead for pharmacists and pharmacy technicians, what levers Chief Pharmacists had to discharge their responsibilities, should issues continue, he told us that these were "limited". He acknowledged that the "ultimate sanction" was moving provider but this was limited by the availability of other providers, was a "significant amount of effort" and could introduce new risks for patients.[189]

108. **Chief Pharmacists are responsible for homecare services in their area but in most cases they do not have the powers or levers to fulfil that responsibility.**

109. ***Chief Pharmacists must have the powers and resources to ensure high quality homecare medicines services in their area. This should include powers and responsibility to develop and support alternative 'back up' provision to deliver homecare medicines services, such as through local pharmacies. This would both empower trusts in their market position, and create a more resilient homecare system.***

184 Written Answer HL9201, Session 2022–23
185 Department of Health and Social Care, 'Parliamentary Under Secretary of State (Minister for Primary Care and Public Health) Neil O'Brien': https://www.gov.uk/government/people/neil-obrien [accessed 26 October 2023]
186 Q 56 (Will Quince MP)
187 Written evidence from Sciensus Pharma Services (HMS0006)
188 Q 39 (Joe Bassett)
189 Q 54 David Webb

Patient recourse

110. We heard that patients do not always understand who to contact with complaints, nor how to access recourse. Ruth Wakeman, representing Crohn's & Colitis UK, told us: "patients are in the dark about who is actually responsible".[190] Richard Bateman accepted that a lack of clarity "must look very frustrating from a patient point of view."[191]

111. The Royal Pharmaceutical Society has published guidance on complaints in homecare services[192] but, as noted in Chapter 2, some patients have experienced difficulty accessing the complaints services of homecare providers or knowing to whom to complain. The CQC explained that poor complaints systems are "a theme across these services".[193] The British Society for Rheumatology agreed that there was a "significant oversight in the design and suitability of patient complaint systems". It argued that this contributes to a lack of awareness from the regulators. It stated that if one patient makes multiple complaints, this will be captured as only one complaint.[194] The British Association of Dermatologists states that: "There is often no complaints procedure".[195]

112. The Parliamentary and Health Service Ombudsman reported to us a case of a patient who had suffered the effects of "failings in care and poor service continued over several years." The patient, 'Mr K', had not been advised of how to escalate his complaint to an appropriate regulator until June 2020, "despite him asking on several occasions over the 2017 to 2018 period." The Ombudsman found that "failings in signposting meant that Mr K could not have his concerns and complaint addressed sooner."[196]

113. Difficulties in accessing complaints systems are particularly concerning given the perspective of the CQC. When asked how patients would identify the relevant regulator to contact, Sarah Billington said this would be "via the provider",[197] but she then said: "From the patient's perspective, they are patients of the acute trust. They are patients of the hospital."[198] As was suggested by Phil White, former Chair of the Welsh Homecare Medicines Committee, these responses demonstrate a lack of clarity about whom enforcement action should be raised against..."[199]

A responsible person

114. Richard Bateman, member of the Royal Pharmaceutical Society Hospital Expert Advisory Group, reported that, since regional Chief Pharmacists are responsible, there are "multiple local conversations trying to deal with the same issues."[200] He argued that raising issues on a regional level prevented teams "linking in with people at a level who can make systemic changes."[201]

190 Q 3 (Ruth Wakeman)
191 Q 18 (Richard Bateman)
192 Royal Pharmaceutical Society, *Homecare Standards*, Appendix 19: https://www.rpharms.com/recognition/setting-professional-standards/homecare-services-professional-standards [accessed 26 October 2023]
193 Q 30 (Sarah Billington)
194 Supplementary written evidence from British Society for Rheumatology (HMS0010)
195 Written evidence from British Association of Dermatologists (HMS0002)
196 Written evidence from Parliamentary and Health Service Ombudsman (HMS0007)
197 Q 24 (Sarah Billington)
198 *Ibid.*
199 Written evidence from Phil White (HMS0016)
200 Q 18 (Richard Bateman)
201 Q 21 (Richard Bateman)

Asked about this, Claire Foreman, Director of Medicines Policy and Strategy at NHS England, emphasised the importance of local management and empowering local areas. She stated that "it is really important that the contract performance is managed at the contract level".[202] This relates to management of individual arrangements rather than providing a point of contact and accountability for the sector as a whole.

115. Alison Davis, Chair of the National Clinical Homecare Association, the trade body for providers, saw a need for "strategic oversight at a much more senior level … nobody is accountable."[203] Sarah Billington, representing the CQC, could not "name a particular person in NHS England" responsible for homecare services.[204] Richard Bateman called for "better accountability right the way through, from the homecare providers, through the trusts and to senior levels in the NHS."[205] He thought: "there needs to be a clear route to escalate issues to a higher national level. I believe this should be a senior, named person within NHS England".[206] The Cystic Fibrosis Trust felt that "without a single entity having a full oversight of the sector, bringing effective solutions will be a challenging task."[207]

116. The Chief Pharmaceutical Officer would be "very interested in exploring" who would take the lead in changes to homecare systems and who would take responsibility.[208] The Chief Pharmaceutical Officer is one potential option—as the professional lead for pharmacists, the post holder is senior enough to drive systems change and is at the heart of NHS England. The Secretary of State for Health and Social Care, or a minister in that department, could take the political ownership of the system.

117. The Minister for Health and Secondary Care, Will Quince MP, stated: "Ultimately, we are responsible in every way. However, the delivery of the service is wholly the responsibility of NHS England, devolved to individual trusts.[209]" However, without levers to discharge their responsibility for homecare, it is difficult to see how staff in individual trusts can be accountable on this issue.

118. ***NHS England should designate a senior, named person with responsibility for the homecare system. That person should be given sufficient powers and resources to discharge that responsibility. Responsibilities should include:***

    (a) ***Setting clear national KPIs for organisations commissioning and providing homecare medicines services to use.***

    (b) ***Collecting data on those KPIs, and publishing data on those KPIs in a way which supports public scrutiny of the homecare medicines system.***

    (c) ***Holding relevant bodies such as individual providers, Chief Pharmacists, the National Medical Homecare Committee and***

202 Q 39 (Claire Foreman)
203 Q 20 (Alison Davis)
204 Q 33 (Sarah Billington)
205 Q 21 (Richard Bateman)
206 Supplementary written evidence from Royal Pharmaceutical Society (HMS0013)
207 Written evidence from Sciensus Pharma Services (HMS0006)
208 Q 47 (David Webb)
209 Q 51 (Will Quince)

pharmacy teams to account for work on homecare medicines services.,

(d) ***Responsibly using new powers to issue appropriate penalties to under-performing providers.***

(e) ***Ensuring trusts or hubs procuring homecare medicines services have access to sufficient financial and expert procurement advice and information, including template legal agreement frameworks, so they are able to effectively deliver value for money services and influence the homecare medicines services market.***

(f) ***Achieving value for money and increasing transparency on homecare funding.***

CHAPTER 8: NEXT STEPS

119. We have identified a number of serious problems in the homecare sector.

- Chapter 1 identified the need for further, urgent review of the homecare sector, and its potential to transform patient care.
- Chapter 2 highlighted the detrimental impact of existing problems on patients and on the NHS.
- Chapter 3 identified a serious difficulty—the lack of transparency within the system prevents anyone from understanding the extent of these problems and how representative they are.
- Chapter 4 found that a lack of support, expertise, and information hindered good purchasing decisions.
- Chapter 5 identified that the regulatory model for homecare is failing to ensure safe care.
- Chapter 6 found a lack of competition in the market, and a failing approach to IT interoperability and electronic-prescribing.
- Chapter 7 has identified a lack of accountability, with no one person or organisation in charge. This makes recourse for patients impossible.

120. These problems are not limited to one area. It has been over a decade since the last full-scale review into this sector. While we have welcomed work by NHS England to review the functioning of the sector, and some welcome steps have been taken, the problems are so broad that a full-scale, Government-sponsored independent review is urgently needed. This must not be allowed to delay action that could be taken more quickly. The Minister for Health and Secondary Care acknowledged this, stating that there were several elements to homecare that, "without needing to see the paper-based exercise, I know we need to get on with and do".[210]

121. ***Following the interim findings of the NHS England review, and by no later than April 2024, the Government should establish and fund an independent review into the homecare system. This review must not delay the enactment of those measures which we, and others, have identified. The review should consider:***

(a) ***The potential role of homecare as a pillar of the future health service;***

(b) ***The extent and impact of existing problems on patients and the NHS;***

(c) ***A radical new approach to transparency and information sharing;***

(d) ***Support and resources required for effective procurement;***

(e) ***Steps to develop a tougher and more proactive regulatory approach;***

210 Q 55 (Will Quince MP)

(f) ***Steps to encourage a competitive and fair market for providers;***

(g) ***Digital infrastructure to support effective delivery; and***

(h) ***Robust governance and accountability arrangements, including ministerial oversight.***

122. We intend to revisit this issue and assess progress against our recommendations in 2024.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

What are homecare medicines services?

1. Homecare medicines services have significant potential to deliver high-quality care to patients in their homes and reduce pressure on hospitals. They should be a key part of future planning and resourcing for the NHS. (Paragraph 5)

2. The homecare sector is highly complex, to the extent that even people working at senior levels find it difficult to understand. This is entirely unacceptable and indicates an urgent need for review and simplification. (Paragraph 12)

3. While we welcome the current work on homecare medicines services, we are concerned that it is vague, lacks specific commitments, and has no clear leadership. Serious problems in homecare have been apparent for over a decade. It is now time for urgent action. Consideration of resource implications must acknowledge future savings resulting from increased efficiency and value for money in a reformed system. (Paragraph 16)

4. *The Department of Health and Social Care should, by December 2023, make a ministerial statement on the findings and proposed actions for NHS England's work on homecare. A further statement should be provided by March 2024 on progress on these actions.* (Paragraph 17)

The problem

5. Delays in providing homecare services can negatively impact on patients physical and mental health. For some, impacts can be serious safety issues and include patients being admitted to hospital or requiring surgery. (Paragraph 32)

6. In some cases the failure of provision of homecare medicines is so severe, or so predictable, that NHS services are compelled to use their resources for services which should be delivered by homecare providers. The NHS can pay twice—once for the homecare provider and, when that fails, to provide the service themselves. (Paragraph 33)

Transparency

7. There is an irreconcilable gulf between the views of clinicians and service users, and that of the leadership and governance bodies in the homecare sector on how well it is performing. While this is a complicated system with multiple variables, we are persuaded by the weight of evidence from service users that there are real and serious problems in the sector. (Paragraph 39)

8. No one—not the Government, not NHS England, not patient groups, not regulators, knows how often, nor how seriously patients suffer harm from service failures in homecare. This indicates a significant failure of oversight and hinders the ability of NHS England to ensure patient safety. (Paragraph 44)

9. *NHS England must identify how many patients have become unwell or have been harmed because of a failure in homecare services. They should ensure that this information is published and shared with relevant parties. It should also form part of the ministerial statements we have requested by December 2023 and March 2024.* (Paragraph 45)

10. Different sets of performance data are available to manufacturers and the NHS. This creates confusion and prevents effective monitoring. (Paragraph 52)

11. *NHS England must develop and implement one consistent set of performance metrics.* (Paragraph 53)

12. Publication of performance data and greater inclusion of patient perspectives in that data are welcome. However, there is a risk that the performance data could be published in such a diluted form that it becomes meaningless. How frequently the data is published, how detailed it is and whether the data is validated will matter hugely. (Paragraph 57)

13. *The Chief Pharmaceutical Officer for England should ensure that the KPI data is published in a consistent, standardised form which is sufficiently specific and regular to ensure meaningful public scrutiny.* (Paragraph 58)

Purchasing

14. The Government does not know how much money is spent on homecare medicines services. It is therefore impossible to make any assessment on value for money. Given that the figure is most likely several billion pounds per year, this lack of awareness is shocking and entirely unacceptable. (Paragraph 60)

15. *The Government must clarify exactly how much public money is spent on homecare medicines services.* (Paragraph 61)

16. Though there is substantial variation, in many cases, those procuring and recommending homecare services appear ill-equipped to do so. In some cases, expertise is missing; in others, there is insufficient information. Given this, and the clear commercial incentives for manufacturers to choose cheap provision, there can be no reliable assurance that a provider is suitable before agreements are made. (Paragraph 73)

17. Given the substantial public cost of homecare medicines, improving procurement processes should be an urgent priority. In their current form, neither the National Homecare Medicines Committee nor regional procurement hubs are equipped to lead the change required. (Paragraph 74)

18. *The review must outline necessary steps towards establishing a central resource of experienced procurement professionals to assist in establishing homecare medicines services. This must be available to all those establishing agreements, whether they are manufacturer- or NHS-funded.* (Paragraph 75)

Regulators

19. The regulatory model for homecare is failing to ensure the safety and quality of patient care. The regulators appear to have a limited understanding of the sector and there appears to be no appetite to find more information. Enforcement action taken against providers, even where avoidable harm has taken place, is feeble. There appears to be no appetite to issue penalties against non-compliant homecare providers. Poor performance can go unchecked. We note the discrepancy between the approach the CQC takes towards small residential homes and that taken towards homecare medicines providers. (Paragraph 84)

20. *The Secretary of State should review the regulatory regime for homecare medicines services, considering in particular the lack of enforcement action taken by the CQC*

against homecare providers where avoidable harm has occurred. The review should identify a lead regulator with the skill and the breadth necessary to take necessary action against providers which are under-performing. These urgent actions should also be reflected in the longer-term review of healthcare regulation. (Paragraph 85)

21. *The Secretary of State for Health and Social Care should instruct the CQC to conduct a thematic review of homecare medicines services.* (Paragraph 86)

State of the market

22. There is a clear perception of a lack of robust competition in the homecare medicines market, in part caused by geographic variation of service levels, barriers to entering the market and poor procurement practices. (Paragraph 91)

23. *As part of a review of homecare medicines services, the Government should work with procurement specialists, the National Audit Office, and the Competition and Markets Authority to identify barriers to competition and effective procurement in the homecare medicines market. They should agree actions to ensure procurement by the NHS or medicines manufacturers achieves value for money.* (Paragraph 92)

24. *A single homecare portal should be created and provided by NHS England. If possible this should be linked with existing online services such as the NHS App.* (Paragraph 98)

25. *More urgency is required in developing Electronic Prescription Systems for homecare providers to use. These must be developed in collaboration between homecare providers and NHS trusts.* (Paragraph 103)

Who is responsible?

26. Chief Pharmacists are responsible for homecare services in their area but in most cases they do not have the powers or levers to fulfil that responsibility. (Paragraph 108)

27. *Chief Pharmacists must have the powers and resources to ensure high quality homecare medicines services in their area. This should include powers and responsibility to develop and support alternative 'back up' provision to deliver homecare medicines services, such as through local pharmacies. This would both empower trusts in their market position, and create a more resilient homecare system.* (Paragraph 109)

28. *NHS England should designate a senior, named person with responsibility for the homecare system. That person should be given sufficient powers and resources to discharge that responsibility. Responsibilities should include:*

    (a) *Setting clear national KPIs for organisations commissioning and providing homecare medicines services to use.*

    (b) *Collecting data on those KPIs, and publishing data on those KPIs in a way which supports public scrutiny of the homecare medicines system.*

    (c) *Holding relevant bodies such as individual providers, Chief Pharmacists, the National Medical Homecare Committee and pharmacy teams to account for work on homecare medicines services.*

    (d) *Responsibly using new powers to issue appropriate penalties to under-performing providers.*

(e) *Ensuring trusts or hubs procuring homecare medicines services have access to sufficient financial and expert procurement advice and information, including template legal agreement frameworks, so they are able to effectively deliver value for money services and influence the homecare medicines services market.*

(f) *Achieving value for money and increasing transparency on homecare funding.* (Paragraph 118)

Next steps

29. *Following the interim findings of the NHS England review, and by no later than April 2024, the Government should establish and fund an independent review into the homecare system. This review must not delay the enactment of those measures which we, and others, have identified. The review should consider:*

(a) *The potential role of homecare as a pillar of the future health service;*

(b) *The extent and impact of existing problems on patients and the NHS;*

(c) *A radical new approach to transparency and information sharing;*

(d) *Support and resources required for effective procurement;*

(e) *Steps to develop a tougher and more proactive regulatory approach;*

(f) *Steps to encourage a competitive and fair market for providers;*

(g) *Digital infrastructure to support effective delivery; and*

(h) *Robust governance and accountability arrangements, including ministerial oversight.* (Paragraph 121)

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Baroness Morris of Yardley (Chair)
Lord Bach
Baroness Bertin
Lord Blencathra
Baroness Campbell of Surbiton
Lord Carter of Coles
Lord Laming
Lord Porter of Spalding
Lord Prentis of Leeds
Lord Shipley
Baroness Stedman-Scott
Lord Willis of Knaresborough

Declarations of interest

Baroness Morris of Yardley (Chair)
No relevant interests to declare
Lord Bach
No relevant interests to declare
Baroness Bertin
No relevant interests to declare
Lord Blencathra
No relevant interests to declare
Baroness Campbell of Surbiton
No relevant interests to declare
Lord Carter of Coles
Chair and Shareholder of Glenholme Healthcare Ltd (providing long-term care of elderly and those with learning difficulties)
Lord Laming
No relevant interests to declare
Lord Porter of Spalding
No relevant interests to declare
Lord Prentis of Leeds
No relevant interests to declare
Lord Shipley
Vice President, Local Government Association
Baroness Stedman-Scott
No relevant interests to declare
Lord Willis of Knaresborough
No relevant interests to declare

A full list of Members' interests can be found in the Register of Lords Interests: https://members.parliament.uk/members/lords/interests/register-of-lords-interests

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at https://committees.parliament.uk/work/7739/homecare-medicines-services/ and available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the Committee is listed below in chronological order of oral evidence session, and then in alphabetical order. Those witnesses marked with ** gave both oral evidence and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

Oral evidence in chronological order

*	Dr Christian Selinger, Consultant Gastroenterologist and Chair of the Inflammatory Bowel Disease Section, British Society of Gastroenterology	QQ 1–15
**	Sarah Campbell, Chief Executive, British Society for Rheumatology	QQ 1–15
**	Ruth Wakeman, Director of Services, Advocacy and Evidence, Crohn's & Colitis UK	QQ 1–15
**	Alison Davis, Chair, National Clinical Homecare Association	QQ 16–23
**	Richard Bateman, Pharmacist and member of the RPS Hospital Expert Advisory Group, Royal Pharmaceutical Society	QQ 16–23
**	Dr Rick Greville, Director, Distribution & Supply and Association of the British Pharmaceutical Industry Cymru Wales at Association of the British Pharmaceutical Industry	QQ 16–23
**	Sarah Billington, Deputy Director of Medicines Optimisation, Care Quality Commission	QQ 24–37
**	Claire Bryce-Smith, Director of Insight, Intelligence & Inspection, General Pharmaceutical Council	QQ 24–37
**	Joe Bassett, Chair, National Homecare Medicines Committee, and Assistant Director of Procurement, Pharmacy and Healthcare Services, East of England NHS Collaborative Procurement Hub	QQ 38–48
**	Claire Foreman, Director of Medicines, Policy and Strategy, NHS England	QQ 38–48
**	David Webb, Chief Pharmaceutical Officer for England, NHS England	QQ 38–48 QQ 49–59
*	Will Quince MP, Minister of State (Minister for Health and Secondary Care), Department of Health and Social Care	QQ 49–59
*	Rahul Singal, Chief Pharmacy & Medicines Information Officer, NHS England	QQ 49–59

Alphabetical list of witnesses

**	Joe Bassett, Chair, National Homecare Medicines Committee, and Assistant Director of Procurement, Pharmacy and Healthcare Services, East of England NHS Collaborative Procurement Hub (QQ 38–48)	HMS0014
**	Richard Bateman, Pharmacist and member of the RPS Hospital Expert Advisory Group, Royal Pharmaceutical Society (QQ 16–23)	HMS0013
**	Sarah Billington, Deputy Director of Medicines Optimisation, Care Quality Commission (QQ 24–37)	HMS0018
	British Association of Dermatologists	HMS0002
**	Claire Bryce-Smith, Director of Insight, Intelligence & Inspection, General Pharmaceutical Council (QQ 24–37)	HMS0011
**	Sarah Campbell, Chief Executive, British Society for Rheumatology (QQ 1–15)	HMS0001 HMS0010
	Cystic Fibrosis Trust	HMS0003
**	Alison Davis, Chair, National Clinical Homecare Association (QQ 16–23)	HMS0012
**	Claire Foreman, Director of Medicines, Policy and Strategy, NHS England (QQ 38–48)	HMS0015
	Dr Olivia Goldberg	HMS0024
**	Dr Rick Greville, Director, Distribution & Supply and Association of the British Pharmaceutical Industry Cymru Wales, Association of the British Pharmaceutical Industry (QQ 16–23)	HMS0009 HMS0019
	Dr Morag Griffin, Leeds Teaching Hospitals NHS Trust	HMS0025
	Dr Anthony Isaacs MBChB BSc FRCP, Consultant Rheumatologist, Clinical Lead for Rheumatology, London North West Healthcare University Trust and Clinical Chair of the North West London sector Rheumatology CRG	HMS0023
	Elizabeth Kirsch, Government Affairs Manager Lloyds Pharmacy Clinical Homecare (Part of Hallo Health Group)	HMS0022
	Parliamentary and Health Services Ombudsman	HMS0007
*	Will Quince MP, Minister of State (Minister for Health and Secondary Care), Department of Health and Social Care (QQ 49–59)	HMS0026
	Sciensus Pharma Services	HMS0006 HMS0017
	Sciensus Pharma Services provided private written evidence	HMS0021
	Scottish Government Pharmacy and Medicines Division on Homecare Medicines Services	HMS0008

*	Rahul Singal, Chief Pharmacy & Medicines Information Officer, NHS England (QQ 49–59)	
	Taskforce for Lung Health	HMS0005
**	Ruth Wakeman, Director of Services, Advocacy and Evidence, Crohn's & Colitis UK (QQ–)	HMS0004
**	David Webb, Chief Pharmaceutical Officer for England, NHS England (QQ 38–48)	HMS0015
	Phil White	HMS0016

APPENDIX 3: GLOSSARY

ABPI	The Association of the British Pharmaceutical Industry is a trade body for drug manufacturers.
BAD	British Association of Dermatologists
BSR	British Society for Rheumatology
CQC	The Care Quality Commission, a public body, is the independent regulator of health and social care in England. It monitors, inspects and regulates services performing regulated activities under the Health and Social Care Act 2008.
CMU	The Commercial Medicines Unit is an NHS England team which works on behalf of the Department of Health and Social Care and the NHS to support those who buy pharmaceuticals for hospitals across the NHS in England.[211]
DHSC	Department of Health and Social Care
GMC	General Pharmaceutical Council
GPhC	The General Pharmaceutical Council is the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in the United Kingdom.
CRG	Clinical Reference Group
MAHs	Marketing Authorisation Holders are individuals or companies who hold legal authorisation to sell pharmaceuticals in the EU. In homecare services, they are generally drug manufacturers who contract with homecare providers to provide a service.
MHRA	The Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components in the United Kingdom.
NCHA	The National Clinical Homecare Association is the trade body for homecare providers.
NHMC	The National Homecare Medicines Committee acts as "the national focus for developing and improving administration and governance processes for medicine homecare services".[212] It includes representation from NHS England, homecare providers, pharmaceutical manufacturing associations and the Care Quality Commission.
NHSE	NHS England
RPH	Regional Procurement Hubs are NHS centres of procurement expertise which can assist hospital trusts to establish or manage homecare contracts.
RPS	The Royal Pharmaceutical Society is the professional membership body for pharmacists and pharmacy students.

211 Department of Health and Social Care, Commercial Medicines Unit (4 March 2011): https://www.gov.uk/government/collections/commercial-medicines-unit-cmu [accessed 22 September 2023]

212 Specialist Pharmacy Service, 'National Homecare Medicines Committee Terms of Reference' (April 2018): https://www.sps.nhs.uk/articles/national-homecare-medicines-committee-nhmc-terms-of-reference/ [accessed 11 October 2023]