ROYAL COLLEGE OF PHARMACY

The Health Bill: House of Commons Committee Stage
Written evidence

1. The Royal Pharmaceutical Society became the Royal College of Pharmacy in April 2026.

2. The Health Bill comes at a crucial time for the health service, with major changes to Integrated Care Boards, a newly published community pharmacy contract[1], and continued uncertainty around the forthcoming NHS workforce plan.

3. As MPs begin to scrutinise the Health Bill, we have urged the Government to support pharmacy teams to help deliver the 10-Year Health Plan, including expanding pharmacist prescribing services and making best use of pharmacists' clinical skills across the NHS.

Pharmacy and delivering the 10-Year Health Plan

4. Pharmacy is the third largest professional group after medicine and nursing. More than 67,000 pharmacists and 28,000 pharmacy technicians work across all care settings, including in community pharmacy, general practice, hospitals, as well as in academia and the pharmaceutical industry.[2]

5. Pharmacists will be central to achieving the ambitions in the 10-Year Health Plan: reducing health inequalities, managing the growing cost of long-term conditions, and delivering best value from medicines for patients and the NHS.[3] They continue to play a key role in vaccinations, maintaining access to life-saving medicines, and supporting patient access to primary care.

6. Pharmacists are experts in medicines, the most common clinical intervention in the health service and a key engine of UK economic growth.

System leadership: Ensuring best value from medicines for patients and the health service

7. As the Health Bill now seeks to transfer functions to ICBs, it is vital that strong pharmacy leadership is retained and visible across the system, from commissioning through to delivery, to safeguard quality, ensure best use of the NHS medicines budget, and deliver on key national priorities.

8. Without appropriate leadership, there is a risk that medicines governance and strategic oversight become fragmented or deprioritised in the move towards provider-led neighbourhood health models. This could weaken action on medicines safety, overprescribing, antimicrobial resistance, and equitable access to NICE-approved treatments. Integrated Care Boards have seen significant budget cuts and disruption to teams, and national funding for Community Pharmacy Clinical Leads to support local service development has not been renewed.

9. As the NHS moves towards greater provider collaboration and localised decision-making, the medicines agenda cannot be treated as an operational afterthought. It must remain a strategically-led function, with appropriate senior pharmacy leadership embedded in every ICB and equivalent structures at place and provider level.

[1] https://cpe.org.uk/our-news/cpe-secures-10-funding-rise-but-pushes-for-reform/
[2] https://www.pharmacyregulation.org/about-us/research/gphc-registers-data
[3] https://www.rcpharm.org/policies/a-vision-for-pharmacy-professional-practice-in-england/

10. Issues such as budget accountability, inequalities in access, antimicrobial stewardship, uptake of new technologies, and the optimisation of high-cost treatments require professional insight and system-wide coordination. Without this, the risks to both value and patient safety are significant. There must be clear accountability and leadership for medicines at national, regional and ICB levels.

11. In June 2025 we wrote to NHS England and called on it to ensure that:

    - Every ICB maintains a designated executive-level pharmacy leader responsible for strategic oversight of medicines.
    - Any transfer of functions to providers is accompanied by clear expectations for clinical governance and pharmacy leadership capacity.
    - The national moderation and assurance process recognises the need for consistency and avoids unintended fragmentation in medicines oversight.
    - Community pharmacy's growing role is matched by appropriate strategic leadership at system and national levels to ensure services are safely and sustainably delivered.

12. In September 2025, NHS England published a 'Medicines Optimisation – Good Practice Document', which had been developed in discussion with Integrated Care Board Chief Pharmacists. This lists core functions of a strategic medicines optimisation function, many of which will underpin the shift towards neighbourhood health, including:

    - Strategic commissioning of community pharmacy.
    - Developing the medicines and pharmacy aspects of neighbourhood teams.
    - Clinical pathway redesign and transformation.
    - Clinical effectiveness, quality and safety oversight for medicines.
    - Prescribing budget accountability and financial risk management.

13. The document warns of 'serious risks to patient care, system performance and financial sustainability' without a strong strategic medicines optimisation function at ICB and system level. However, our members have also warned that the significant disruption to national, regional and system-level teams means there will be insufficient oversight of ICB plans and whether this good practice will be followed.

14. The pharmacist workforce is evolving rapidly. With thousands now trained as independent prescribers, there is an unprecedented opportunity to deliver more care closer to home, tackle long-term conditions earlier, and shift demand from hospitals to the community. But this transformation can only be successful with system-wide leadership that supports integration, develops new models of care, and ensures patient access to safe, evidence-based treatment.

15. The NHS in England spends more than £19 billion on medicines each year – the second largest expenditure after workforce.[4] In the context of new trade deals on medicines, and adjustments to the QALY threshold, it is more important than ever that pharmacists are adequately resourced and that systems are appropriately incentivised to optimise medicines for patients and reduce overprescribing.

[4] https://www.england.nhs.uk/medicines-2/medicines-value-and-access/

Key questions:

- *How will ICBs plans be evaluated by regional and national teams to ensure medicines optimisation best practice is followed?*
- *How will pharmacy system leadership roles be supported, both within ICBs and across primary and secondary care, to support commissioning and service development?*
- *How will outcomes be measured and published to address unwarranted variation, such as around patient safety and patient access to NICE-approved treatments?*

NHS England

With the abolition of NHS England, it is crucial that policymaking continues to be informed and shaped by appropriate pharmacy expertise, with key issues including:

- National leadership around the complex policy and regulatory landscape of homecare medicines, as highlighted by the House of Lords Public Services Committee inquiry.[5]
- Sustained investment in aseptic pharmacy services to keep pace with demand, supporting preparation of antibiotics, chemotherapy and cutting-edge medicines.
- Managing medicines shortages and securing patient access to medicines in a complex global market.
- Future policy development to make best use of pharmacist prescribing skills across primary and secondary care to deliver national strategies, including implementing lessons learned from the community pharmacy pathfinder programme.[6]
- Reducing hospital admissions and patient harm from Adverse Drug Reactions, which cost the NHS over £2 billion each year.[7]
- The role of pharmacy teams supporting increasingly complex patient care in hospitals, and addressing the variable adoption of electronic prescribing.

Single Patient Record

16. The move towards a single patient record will mean that vital information follows people wherever they access the NHS. With pharmacists providing more clinical services, managing long-term conditions, optimising medicines and reducing harm, it is essential they are included in full access to the record from the outset, as well as involved in testing and design. Appropriate safeguards and informed consent mechanisms will be crucial to ensuring public trust and confidence, alongside efforts to support digital inclusion.

Patient experience and patient safety

Healthwatch

17. Local Healthwatch play a crucial role as patient champions, supporting service improvement and providing patient education and signposting. Healthwatch England continues to a valuable contribution to national policy debates, including on community pharmacy. It is unclear how this ability to consider national trends and conduct impartial, independent

[5] https://lordslibrary.parliament.uk/house-of-lords-public-services-committee-report-homecare-medicines-services/
[6] https://research.manchester.ac.uk/en/projects/evaluation-of-independent-prescribing-in-community-pharmacy-pathf/
[7] https://pmc.ncbi.nlm.nih.gov/articles/PMC11949333/

analysis will be maintained by the proposal to create a central Patient Experience Directorate within Government, and move local patient engagement to ICBs – themselves already facing 50% cuts.

18. As the King's Fund commented:

    - "Whatever replaces Healthwatch must build on the core conditions that enabled it to have a positive impact: a voice independent of government and services; the capacity to gather unsolicited, varied and rich community insight, including from seldom heard groups; and a geographical scale that supports both local insight and system or national-level influence."[8]

Health Services Safety Investigations Body (HSSIB)

19. As the Committee has already heard, there are clearly questions around the future independence of the HSSIB as part of the Care Quality Commission. This could impact its ability to conduct crucial healthcare safety investigations, offer a safe space for protected disclosures, and make recommendations for any part of the system.

Reducing inequalities

20. The Bill places a duty on the Secretary of State to have regard to reducing inequalities around health outcomes and access to health services. With changes to the commissioning landscape, it will be crucial to monitor variations in both patient access to services and outcomes, between and within ICBs. Equally, new pharmacist prescribing services, including through Pharmacy First, must be adequately supported and resourced to avoid a postcode lottery for patients.

21. One avoidable inequality and barrier to patient care is the prescription charge, which costs patients in England more than £650 million each year.[9] Patients in Wales, Scotland and Northern Ireland do not pay a prescription charge at all. More than a third of pharmacists (35%) have said they had seen an increase in patients declining prescriptions owing to the cost.[10] The type of medicines being declined include those for blood pressure, inhalers, pain relief, statins and mental health. Prescription charges increase the risk of avoidable hospital admissions when they stop people from taking medicines they need to stay well. This worsens health outcomes and adds further pressure on the health service.

22. In 2021 the Government closed a consultation on raising the qualifying age for free prescriptions but did not proceed with the change. While the Government has kept the prescription charge at £9.90 and introduced a reduced-price Prescription Prepayment Certificate for Hormone Replacement Therapy, it has not yet acted on calls by patient groups, professional bodies and trade unions for a wider review of the prescription charges system. The Prescription Charges Coalition continues to call for a review of the medical exemptions list for people with long-term conditions. The last review was conducted in 2009 and noted that the issue was 'at the heart of the core principles of the NHS'.[11]

[8] https://www.kingsfund.org.uk/insight-and-analysis/reports/learning-from-healthwatch
[9] https://www.gov.uk/government/consultations/aligning-the-upper-age-for-nhs-prescription-charge-exemptions-with-the-state-pension-age/outcome/aligning-the-upper-age-for-nhs-prescription-charge-exemptions-with-the-state-pension-age-government-response
[10] https://www.rcpharm.org/news/pharmacists-warn-of-impact-of-prescription-charges-on-patient-care/
[11] https://assets.publishing.service.gov.uk/media/5a750d2d40f0b6360e472f4e/dh_116367.pdf

23. In an NHS free at the point of use, alongside a cost-of-living crisis and a desire to shift care from hospitals to the community, patients should not have to pay for their medicines depending on where they are dispensed. The prescription charges system in England is confusing for patients, risks people not taking their medicines they need to stay well, and takes time away from health professionals who want to focus on patient care – it should be abolished.

Performers List

24. The current 2006 Health Act already has provision for NHS England to create a 'performers list' for those providing pharmaceutical services. The Health Bill would transfer these existing powers from NHS England to the 'Secretary of State or an NHS body'. Currently, any GP, optometrist or dentist offering primary care in an NHS setting is required to be registered on the Performers List for England.[12] This is a list of approved GPs, opticians and dentists who satisfy a range of criteria necessary for working in the NHS.

25. With efforts to care for more patients closer to home and as pharmacists play an increasingly clinical role in primary care, there is an emerging debate about whether pharmaceutical services should also have a performers list. This could be one approach to assuring health professionals are qualified and competent to provide safe and effective care. This could also provide an additional mechanism other than a Fitness to Practice referral to the regulator.

26. However, further exploration of a performers list would first require meaningful engagement with the profession and stakeholders. With continued pressures on pharmacists, pharmacy technicians and across the health service, the aim of this policy must be seen as supporting health professionals to meet a standard and not simply another performance management tool. Further considerations would include ensuring sufficient resources for implementation; adequate provision of support for health professionals to meet required standards, in line with other professions; the potential impact on pharmacists' capacity to work across different care settings; and alignment with existing approaches to assurance, including RCPharm Credentialling.

Workforce plan

27. Making a success of the 10-Year Health Plan will depend on having sufficient capacity and skills within the workforce to deliver it – and the Bill places a statutory duty on the Secretary of State to exercise functions around education and training to meet the workforce needs of the health service.

28. While we welcomed the Government's constructive engagement with stakeholders on the workforce plan in 2025, it is yet to be published. It remains unclear whether the plan will support and unlock the potential of pharmacists, pharmacy teams and the wider health professions to maximise their role in patient care.

29. The health service is under continued pressure, with 86% of pharmacists at high risk of burnout.[13] In our recent evidence to the Health and Social Care Select Committee on neighbourhood health[14], we called for the workforce plan to address:

[12] https://pcse.england.nhs.uk/services/performers-lists
[13] https://www.rcpharm.org/news/annual-rps-workforce-wellbeing-survey-results/
[14] https://committees.parliament.uk/work/9455/delivering-the-neighbourhood-health-service-workforce/

- Support for staff wellbeing to boost retention and fostering diverse leadership and inclusion.
- Protected time for professional development, system leadership and developing new services.
- Funding for upskilling and training, including access to training around digital technology in healthcare delivery.
- Measures to support workforce transformation and assurance, moving towards a nationally recognised mechanism to define, assess and assure the advancing capabilities of pharmacists across care settings, as supported by RCPharm Assessment and Credentialing.[15]
- Making the most of the whole of the workforce – including through pharmacist prescribing services.

30. With growing demand for pharmacists' expertise to support medicines safety and deliver more clinical care, this must also be matched by sufficient clinical supervision and training capacity to secure a sustainable pipeline of future pharmacists. This includes increasing access to Designated Prescribing Practitioners, ensuring that pharmacists are appropriately supported to undertake the DPP role, with dedicated time to train, supervise and support trainees.[16]

Equal support for pharmacy students

31. As pharmacists play a growing clinical role in the health service, they must be given comparable access to the training and development support provided to other healthcare professions.

32. As the pharmacy degree has evolved to include a greater emphasis on clinical practice and prescribing, we wrote to the Minister of State calling for pharmacy students to be able to access all elements of the Learning Support Fund, including parental support.[17] Students should not face additional financial barriers to choosing pharmacy. With 89% of UK-registered pharmacists having been trained in the UK, the Government should take the logical next step to remove this inequity and ensure that pharmacy students can access the support they need.

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[15] https://www.rcpharm.org/credentialing/
[16] https://www.rcpharm.org/campaigns/support-for-pharmacist-designated-prescribing-practitioners/
[17] https://www.rcpharm.org/news/rcpharm-writes-to-government-on-learning-support-fund/