House of Commons

Health and Social Care Committee

Government Response to the Health and Social Care Committee's Expert Panel: Evaluation of Government's commitments in the area of the pharmacy in England

Thirteenth Special Report of Session 2022–23

Ordered by the House of Commons to be printed 18 October 2023

Published on 19 October 2023
by authority of the House of Commons

Health and Social Care Committee

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Thirteenth Special Report

The Health and Social Care Committee published its Tenth Special Report of Session 2022–23, Evaluation of the Government's commitments in the area of pharmacy in England (HC 1310), on 25 July 2023. The Government response was received on 20 September 2023.

Appendix: Government Response

Introduction

On 25 July 2022, the Health and Social Care Select Committee's Expert Panel published its report 'Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England.

The Department of Health & Social Care welcomes the Health and Social Care Committee's report, and we are grateful to everyone who contributed their time and expertise to the evaluation. Whilst we do not recognise the overall rating of 'requires improvement' as reflective of progress to date and plans in place, the report provides important insight and feedback regarding how these commitments are perceived and ways these commitments could be strengthened.

This report focused on nine commitments that the Expert Panel selected from a list of 39 provided by the Department. We welcome the Panel's view of the importance Pharmacy can have and the recognition of the 'significant progress' made in some areas. We also note the Expert Panel's comments regarding workforce and digital maturity which were subject to previous evaluations and to which we have responded. Action in these areas has been set out in the NHS Long Term Workforce Plan and the Delivery Plan For Recovering Access to Primary Care. These, along with the continued work set out in our submissions to the Expert Panel, demonstrate the Government's commitment to enabling pharmacy to maintain a central role in the NHS.

Expert Panel Report Summary

The Expert Panel focussed on nine commitments, outlined below, and rated the Government's progress against each of these commitments using a 'Care Quality Commission-style' (CQC) rating. The overall rating across the nine commitments was 'requires improvement'. The CQC-style ratings for each of the commitments are summarised on pages 4- 7.

The commitments:

Policy area	Government Commitment
Community Pharmacy	Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS.
	Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery.
Integrated care (including patient safety)	Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E.
	Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service').
Hospital pharmacy	To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024. To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation.
Workforce education and training	A further 3-year programme of education and training for PCN [Primary Care Network] and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists.
	Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists.
Extended services	Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF.

Each of these commitments was rated against several key questions:

- Was the commitment met overall? Or is the commitment on track to be met?
- Was the commitment effectively funded (or resourced)?
- Did the commitment achieve a positive impact for patients and people in receipt of care?
- Was it an appropriate commitment?

Each of these questions were then rated, with a combined rating then applied to the commitment as a whole. The Expert Panel's approach was not a formal technical evaluation of the impact of different interventions on the policy aspirations and should not be viewed as a substitute for Government commissioned evaluations via the National Institute for Health and Care Research (NIHR). Government and stakeholders were invited to submit written evidence, with round table events arranged for pharmacy professionals, people who regularly access pharmacy services for themselves or someone else, and advocates for people in receipt of social care and patients.

The responses were analysed, and the Panel rated each commitment as follows:

Community pharmacy

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS.	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery.	Inadequate	Good	Requires Improvement	Good	Requires Improvement

Hospital pharmacy

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024.	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation.	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement

Integrated care (including patient safety)

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E.	Good	Requires improvement	Good	Good	Good
Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service').	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Workforce education and training

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists.	Requires improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists.	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Extended services

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF.	Good	Requires improvement	Requires improvement	Good	Good

Community Pharmacy

Commitment 1: Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS. (Requires improvement)

Commitment met	Funding & resource	Impact	Appropriateness	Overall

The Expert Panel found this commitment 'requires improvement' whilst acknowledging that progress on meeting the commitment has been 'good'.

The Department welcomes the Expert Panel's recognition that the commitment to maintain the Pharmacy Access Scheme (PhAS) has been met. The aim of the PhAS is to ensure that a baseline level of patient access to NHS community pharmaceutical services in England is supported. The PhAS is not designed to replace the Local Pharmaceutical Services (LPS) provisions as suggested in the Panel's report. Pharmacies deemed eligible for PhAS receive an additional monthly payment from the CPCF. The PhAS has been designed to support the pharmacies that are most important for patient access, specifically those pharmacies where patient and public access would be materially affected should they close. The PhAS takes isolation and need levels into account.

Distances between pharmacies for the 2022 PhAS have been measured by road distance rather than as the crow flies previously used and are therefore more representative of patient walking journeys. The data for the 2022 PhAS is based on Ordnance Survey. This includes taking account of footpaths. For these calculations, public transport travel distances were not taken into account because of the regional variability of provision of public transport, and because public transport timetables are subject to change and would therefore not have been a robust basis for distance calculations. Walking distance has been deemed to accurately reflect equal access to patients irrespective of their location.

Despite finding this commitment had been met, the Panel rated the funding, impact and appropriateness of the commitment as 'requires improvement'. When the PhAS was initially introduced in 2016, payments were calculated as a top-up to provide an equivalent overall payment to account for the funding reduction for each pharmacy's 2015 payments, taking into account a small efficiency saving. A new payment allocation model was developed in 2022 to encourage growth for smaller pharmacies and minimise reliance on this additional support for larger pharmacies that are able to remain viable through the provision of NHS pharmaceutical services.

Pharmacies receive income from the NHS funding for medicines and services, locally commissioned and private services and sales of medicines, appliances or other products. PhAS payments do not intend to compensate for the difference between income required to make a pharmacy viable and income generated by the business. Instead, the PhAS provides a small regular top up to income, the payment amount that does not fluctuate from month to month and is not dependent on factors that may affect fluctuation in income a pharmacy can generate through its business activities. It aims to provide a certain stability to business owners and is not sufficient alone to ensure business viability.

There are other additional provisions in place to help secure patients access to medicines and pharmaceutical services. There remains the ability for Integrated Care Boards, the commissioners of pharmaceutical services, to commission local pharmaceutical services via local pharmaceutical service contract. In rural areas designated as controlled localities by NHS England patients who live more than a mile from a pharmacy can also access medicines through their general practice subject to approval from an ICB. In addition, a growing number of patients are accessing their medications via on-line provision.

The Expert Panel considered that the PhAS is not enough to prevent closures and is too narrow in scope to address the funding challenges faced by the sector. However, the PhAS was never intended as a general means to prevent closures or ensure fixed funding levels.

Commitment 2: Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery (Requires improvement)

Commitment met	Funding & resource	Impact	Appropriateness	Overall

The Panel has given an overall rating for this commitment of 'requires improvement' noting feedback raised about the level of funding currently available to the sector and the perceived lack of evidence to demonstrate the impact made.

The Panel have given the delivery of this commitment a rating of 'inadequate' suggesting no appropriate review of the funding model had been undertaken because the evidence received suggested funding for community pharmacy is not sufficient. The commitment however was to review the funding model and the balance between spend on dispensing and services. The overall level of funding remains subject to affordability and consultation with the sector on the activity that can be delivered within that funding envelope. The level of funding for the CPCF 2019–24 five-year deal was agreed between DHSC, NHSE and CPE in 2019. In that document we set out how we envisaged the shift of funding towards services would emerge over the course of the 5 years. DHSC and NHSE continue to monitor and discuss progress with the Community Pharmacy England on a regular basis. We therefore do not agree with the Panel's rating that this commitment has not been met/requires improvement.

In this context it is worth noting that an additional £100 million was made available to community pharmacy across this and last year and that the Delivery plan for recovering access to primary care announced up to £645 million for a new Pharmacy First service and expansion of the existing Blood Pressure Check and Contraception services. In addition, NHSE has committed to an Economic Analysis of the sector. This analysis will look at the cost of providing NHS pharmaceutical services and will inform any future funding arrangements. This analysis was referenced by Community Pharmacy England in their evidence submitted to the Panel alongside their own independent analysis to assess the sector.

We are pleased to note the panel is content that the funding and appropriateness of this commitment are each rated as 'good'. We also note the Panel's rating of the Impact of this commitment as 'requires improvement' but this rating is in part linked to the Panel's findings that no review of the level of funding has been done. We have set out above that this is not the case.

Integrated Care

Commitment 3: Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E (Good)

Commitment met	Funding & resource	Impact	Appropriateness	Overall

The Expert Panel reported an overall rating for this commitment as being 'good'. The report noted that the service has been successfully rolled out, and evidence showed Community Pharmacy Consultation Service as being widely seen as enabling community pharmacy to support more people with minor conditions and freeing up capacity within other parts of the health service to manage more complex conditions.

The Department welcomes the recognition of the Expert Panel of the successful roll out of the commitment to deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E, and its overall rating as being 'good'.

In October 2020, funded resource was included in the regional implementation plans developed as part of the Primary Care Access Improvement mobilisation programme. Each region engaged with the programme and NHS England funded regional implementation managers were recruited to post. Their role was to lead the implementation of the GPCPCS referral pathway across the Clinical Commission Groups (CCGs) in each region. Additionally, each CCG appointed an Implementation Manager to coordinate implementation activity across the CCG in general practice, collaborating closely with Local Pharmaceutical Committee (LPC) representatives to support community pharmacy engagement. The national programme was coordinated by the national Pharmacy Integration team providing leadership across all regions.

In October 2020, a procurement exercise by NHS England seeking specific support for general practice was also started. As noted in the report, the impact of the pandemic on resource planning and healthcare provider access issues resulted in an 18-month delay in commencement of the procurement exercise.

We acknowledge the Panel's comments regarding funding which was found to 'require improvement'. However, we note the varied feedback from those who contributed to it, indicating this was not an agreed position across the sector. The funding and support were agreed early in the process and the pandemic response, and its impact on GP and community pharmacy access, delayed the full benefit from the investment being realised.

The report also highlights challenges found by the sector regarding the IT systems connected to CPCS. There has never been a single national IT platform for CPCS. At CPCS 'go live' in October 2019 there were two IT supplier solutions available (Sonar Informatics® in London and EMIS Health/PharmOutcomes® in the rest of England).

A licence for the IT supplier was held by each NHS England region to enable rapid mobilisation of the service at launch. In line with the negotiated agreement set out in the five year CPCF deal, this arrangement was always intended to be time limited. In actual fact, NHS England continued to centrally fund these licences for a further 12 months beyond the negotiated agreement, due to the pandemic. Notice was given to pharmacy contractors that these licences would expire from 1 April 2022 at which point the responsibility for procuring an IT solution that met the minimum digital requirements for CPCS passed from NHS England to the pharmacy contractor (referred to as the 'provider pays' model in the report).

Since April 2022 there is now a choice of four approved CPCS IT suppliers' products which can support CPCS referral management:

- Cegedim Healthcare Solutions®,
- EMIS Health /PharmOutcomes®,
- Sonar Informatics®,
- Positive Solutions®.

All four suppliers are currently implementing a new digital referral standard (i.e., the Booking and Referrals Standard (BaRS) to receive GP referrals in a pharmacy setting. BaRS will enable GPs to send relevant data items to enable the pharmacy to accept the patient into the service. GP Connect Access Record will be used to retrieve data from the patient's GP practice record e.g., medication, allergies.

Once implemented, IT suppliers should find it easier to implement a single, agreed national interoperability standard (rather than supporting multiple and varied standards). BaRS also supports the integration of care journeys across care settings using existing IT systems. The implementation of BaRS will be a significant step forward for better digital integration.

The Panel did report the positive impact achieved through this commitment as well as its appropriateness, awarding each a 'good' rating. The Department is pleased with this recognition, but acknowledges the comments made in the report regarding the need for evaluation of the service. Since the launch of the service in 2019 we have seen over 2.8 million referrals into the CPCS, and we will endeavour to continue to monitor the outcomes of the service to ensure this continued positive impact is maintained.

We are also pleased to see the positive recognition of this commitment by both the Panel and providers, noting NHS Gloucestershire ICBs comments:

> "This commitment is moving healthcare in the right direction, with community pharmacies managing more of the low acuity patients leaving General Practice to manage more complex issues. This will ultimately lead to meaningful improvement."

Commitment 4: Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service'). (Requires improvement)

Commitment met	Funding & resource	Impact	Appropriateness	Overall

The expert panel found that overall this commitment 'requires improvement'. Its report noted the service can be beneficial to patients and the health service but that implementation had been negatively affected by IT problems. It reports that these problems have been compounded by staff shortages and lack of funding.

The Department does not agree with the report's findings that the commitment 'requires improvement' in order to be met. As stated by the Panel, "the commitment, as worded, is focused on introducing the service". It is the view of the Department that the commitment as worded is therefore met. The NHS Discharge Medicines Service (DMS) was launched as an essential service in community pharmacies in February 2021, meaning all Pharmacies are mandated to provide the service. This opinion is supported in the report by PSNC (Now Community Pharmacy England) and Surrey Heartlands ICB who stated that DMS had been successfully commissioned on schedule and with clear national deadlines.

The service starts with a referral from a hospital. NHSE therefore ensured that the DMS was aligned to CCG (now ICB) operational/ planning guidance as well as NHS DMS being part of the NHS Standard Contract. A Commission for Quality and Innovation (CQUIN) financial incentive for Trusts was developed for 2022–23. We note the comments made regarding the CQUIN targets being too low to be effective. Data from 2022–23 CQUIN shows that 52% of acute trusts referred more than the upper threshold (1.5%), with only 5% lower than the 0.5 limit. We would also highlight the lag in data for the service of around 3 months, which does show a steady increase in referrals since evidence was first submitted to the Panel.

Our data also shows wide variability in referral rates across the country. The factors behind this variability will be varied but it is clear that those areas that engaged early with the programme are currently performing best. We acknowledge the impact of the pandemic, circulating Covid-19 and flu over the launch period. Where this service has yet to be established, this will have had an impact on the hospital teams ability to develop and embed referral pathways to community pharmacy.

We also acknowledge the challenges reported regarding the IT systems. We have sought to address these. In January 2022, NHS England worked with NHS X, who offered every NHS Trust funding to support IT solutions to assist delivery of DMS, (either development or buying licences); a total commitment of £1m.

We continue to take action to improve the take-up of this service as part of wider reviews on the implementation of the services set out in the 5 years Community Pharmacy Contractual Framework. As an example, the Pharmacy Integration Fund created a number of new roles for regions and systems that directly or indirectly supported NHS Trusts to set up referral systems into NHS DMS for their patients on discharge. Many of these roles were not fully established until 2023. Specifically:

- Regional Senior Pharmacy Integration Leads were established, to provide regional leadership for community pharmacy clinical services.
- Community Pharmacy Clinical Leads were established; one per ICS for local leadership and supporting implementation of community pharmacy clinical services.
- In addition, NHS England made funding available for project management support for Trusts to implement NHS DMS; equivalent of 0.2wte Agenda for Change Band 7 for every Trust.

These new support roles have started to engage with low referring Trusts to identify and tackle barriers to making referrals to the service. It also remains important to share best practice and to this end NHSE have also launched the FutureNHS collaboration space and peer to peer discussion forum for trusts to seek support and learn from others who have successfully implemented.

The Panel also reported that the appropriateness of the commitment 'requires improvement'. The Department acknowledges the comments that the scope of this commitment is too narrow and the suggestion that it should have been mandatory for Hospitals to refer to the service. This commitment was made as part of the Community Pharmacy Contractual Framework, which sets out how the government will work with Community Pharmacy Contractors to deliver NHS services. It would not have been an appropriate document to set out binding requirements on NHS Trusts as set out above support and incentives have been provided separately to NHS Trust to implement the referrals into the new service and we continue to work with them to realise the demonstrated benefits of this new service for patients which were fully recognised by those who contributed to the report. The Department is pleased that Panel have recognised this in their 'good' rating for impact.

Hospital pharmacy

Commitment 5: "To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024."

Commitment met	Funding and resource	Impact	Appropriateness	Overall

The Department acknowledges the 'inadequate' rating the Panel has given to the delivery of this commitment. Throughout the report—the Electronic Prescription Service (EPS), Electronic Prescribing and Medication Administration (ePMA) and the term "electronic prescribing" have been used interchangeably, which may lead to some confusion. For clarity the definitions are:

- **Electronic Prescription Service (EPS)** is a digital system used to send and receive prescriptions securely between prescribers and community pharmacies. EPS can be thought of as the "carrier" of a prescription message in a secure way between individual prescribing, dispensing IT systems and reimbursement through NHS BSA.
- **Electronic Prescribing and Medicines Administration (ePMA)** refers to IT systems that are predominantly used in hospital inpatient and outpatient settings,

which give clinicians the ability to record prescribing and administration records digitally. ePMA systems are either part of Electronic Patient Record (EPR) systems, or provided as a different system, which may or may not be integrated with the EPR.

- "**E-prescribing**" is the broad process by which prescribers can enter medicines information into an IT system to generate a prescription or a direction to administer a medicine.

The report gives an 'inadequate' rating to the delivery of this objective, noting the high variation in digital maturity of NHS Trusts. The Department is however pleased the see the report recognise the work being done to promote the growing digital maturity and the noted pockets of excellence, with some Trusts on track to meet this commitment. However, we also acknowledge more work is needed and note the comments from ICBs that they will not meet the commitment due to their digital maturity. There is a degree of variation in the implementation of ePMA systems in NHS Trusts. This includes some parts of services not using ePMA (e.g., specialist units) and for some groups of medicines (e.g., IV fluids). The reasons for this will vary depending on the organisation, but it is suspected to be related to technical functionality limitations of the systems for more complex prescribing requirements.

The priority for NHSE has been on "levelling up" digital maturity, ensuring all NHS trusts are using the EPR.

The most recent results of the NHS England Digital Maturity Assessment (DMA) shows that at least 80% of providers have some form of electronic prescribing system (ePMA) already—varying degrees of maturity but all on the journey to meet the 2024 commitment. It is expected the remaining 20% of organisations will have implemented ePMA by 2026, in line with the trajectory for EPR systems, which is being led through the NHSE Frontline Digitisation Programme.

The Department accepts there remains a level of prescribing on paper, through either paper FP10s or local prescription proformas in outpatient-based services. This includes urgent and emergency care, specialist clinics and healthcare services (homecare). NHS England has delivered on part of the commitment to modernise EPS and release the Fast Health Interoperability Resource (FHIR)application programming interface (API). This provides the standard and capability for ePMA systems to provide this functionality to hospitals. This is dependent on individual system suppliers commencing the development and assurance work. We will consider this along with the Panel's previous comments on the evaluation of Government's commitment made on the digitisation of the NHS as referenced in this report. This will inform the next iteration of the national Digital Maturity Assessment will be revised and updated to deliver more in-depth detail about implementation of ePMA, EPS and electronic prescribing across NHS. The implementation of the interoperable medicines standard ISN will also support the digital infrastructure to maximise benefits from e-prescribing.

The Department also acknowledges the comments In the Panel's report and rating of the funding and resource associated with this commitment as "requires improvement". While there has been funding to support the deployment and implementation of ePMA in hospitals, we note there has not been dedicated funding centrally to enable the

implementation of EPS into hospitals, only funding to support the modernisation of the national infrastructure. We also acknowledge the challenges highlighted regarding accessing the available funds. However, local hospital teams are responsible for continuing to optimise and seek benefits from their ePMA systems through continuous improvement. Support and guidance is provided through the national teams for this, in terms of support networks for sharing best practice and resources. There are parts of the report that refer to medicine's automation, which is out of scope for this commitment. The majority of electronic prescribing that occurs across the NHS, in particular primary care is supported by EPS. Over 90% of prescriptions are transmitted digitally through EPS in primary care. EPS can be introduced into additional care settings, including hospitals, dispensing doctors, dentistry and healthcare services. We acknowledge that there has not been dedicated funding centrally to enable this implementation.

The Department acknowledges the comments on the potential impact of this commitment and the 'requires improvement' rating provided. We acknowledge the concerns raised regarding possible digital exclusion for some people, and will consider the feedback and comments in this report. However, we would point to the comments in the report regarding the "well documented" benefits referenced by the RPS.

The Department disagrees with the Panel's findings that the commitments appropriateness is 'inadequate'. We acknowledge the consistent comments from the Panel that greater consideration of the risks of digital isolation is required. However, we would point to the additional evidence we provided, as acknowledged in the Panel's report, that this point is under consideration. However, we accept that the deadline for completion of this commitment is unlikely to be met at.

Commitment 6: To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation. (Requires improvement)

Commitment met	Funding and resource	Impact	Appropriateness	Overall

The Department acknowledges the Panel's findings that this commitment 'requires improvement'.

We acknowledge the comments from stakeholders within the report and the Panel's rating of 'inadequate' against our delivery of this commitment. The panel focused mainly on the evidence around delivering the aseptic hubs, rather than the breadth of initiatives recommended by the report of the Carter review, 'Transforming NHS Pharmacy Aseptic Services in England'. However, the other initiatives are required to ensure delivery and success of the aseptic hubs and their implementation will address some of the concerns raised by the Panel with respect to practical challenges, including gaps in the workforce needed, legislative requirements, lack of modernisation (including digital), challenges with industry capacity and partnership and funding issues.

All these issues are highly relevant and accounted for within the NHS England Infusions and Special Medicines Programme, in which workstreams for workforce, innovation

and technology, finance and contracting, regulation and standardisation are all essential enablers to not only the development of aseptic hubs but for the transformation of aseptic medicines services in England to benefit patients.

For example, new guidance for quality assurance in unlicensed NHS aseptic units was completed in March 2023 and a new supporting digital system for monitoring and reporting on these services has been established. Work to standardise aseptic products is underway which will reduce variation and enable common production protocols which can then feed into standardised training. A series of strategic engagement workshops between the NHS and independent compounding industry suppliers are nearing completion. These will culminate in new ways of contracting to support increased resilience and encourage investment in additional capacity and technology. Progress with these initiatives will enable and ensure success of the recommended aseptic hub and spoke delivery model.

The Department is disappointed by the Panel's rating that the funding for this commitment 'requires improvement'. We feel this takes a negative view to the pilot approach and assumes the worst despite a clear funding and resource plan for this commitment where evidence is not currently available.

As set out, in 2021, a bid for £275m was made to implement the recommended hub and spoke aseptic model in England, of which £75m was awarded to fund a small number of 'pathfinder' hubs. The build, commissioning and development of the five pathfinder aseptic hubs will take place over two to three years with production starting in 2024/25 and increasing in a phased approach through 2025/26 and 2026/27. During this period the national enabling workstreams and pathfinder hub projects themselves will develop and implement solutions to ensure that once the facilities are ready the hubs can become fully operational and optimally productive in accordance with their plans. The Panel quite correctly considers that the pathfinders will not create enough capacity to meet the increased demand for aseptic medicines in the future. A key purpose of the pathfinders is to gain real world data on the costs and timescales to build these facilities and how quickly that can be done whilst meeting all the necessary quality and safety requirements. The Panel also points out that the initial bid for funds to create a national network for England may not be sufficient. The costings from 2021 will be revised for a future funding bid in 2026, using learning from the pathfinders which will reflect the increase in prices for technical equipment and construction.

The Department is pleased that the Panel agree to the positive impact of this commitment, giving it a 'good' rating at the positive light with which the commitment is viewed in this regard. We are also grateful for the feedback of the stakeholders and note the positive feedback they provided about the pilots and the potential success for this commitment if rolled out further.

We note the Panel's rating that this commitments appropriateness 'requires improvement', and the concerns they raise. We welcome the Panel's assessment that the aim of the commitment is wholly appropriate and that there is potential for positive patient impact when the commitment has been fully met.

One of the main issues identified in the Panel's report is the need for an appropriately trained and skilled workforce. This is crucial to the success of the new aseptic hubs and to continued services from spoke aseptic compounding units in local hospitals. In

recognition of this, the Infusions and Special Medicines Programme has a significant workforce focus. Working with the five aseptic hub pathfinders, national and regional workforce development leads, technical service training specialists and NHS and industry frontline service representatives, the programme has identified the following priority actions which are all underway and aiming to complete by the end of 2024:

- Use workforce data to understand the current workforce and gaps. Use workforce analytics to model changing demand and develop strategies to create a sustainable workforce including apprenticeships and better use of skill mix.
- Define tasks carried out in aseptic and production units and the competencies required to undertake them. Agree principles to standardise roles and define career pathways for all staff groups to enable better career progression.
- Undertake a gap analysis of existing education and training provision to ensure that training is available and accessible to develop the knowledge, skills and competence to meet the standardised role requirements

Historically the aseptic service workforce has primarily consisted of registered pharmacy professionals and pharmacy support workers. Pharmacists and pharmacy technicians are increasingly supporting medicines optimisation through clinical face to face patient services in accordance with the NHS Long Term Plan strategy and the professions' modernised initial education and training standards, moving away from more technical roles.

Workforce, education and training

Commitment 7: A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists (Requires improvement)

Commitment met	Funding and resource	Impact	Appropriateness	Overall

The Department acknowledges the comments from the Panel and its rating that this commitment 'requires improvement'.

We welcome the Panel's comments about the "encouraging signs that the commitment is on track to be met", and suggest that, as stated and in line with the approach taken in this report, this commitment is met. However, we acknowledge the challenges and comments made in this report, and as set out in our supplementary response, have further plans in this area.

By March 2023 nearly 7,000 pharmacy professionals had enrolled for the ARRS funded training. The 18-month training programme for pharmacists and 15 months for pharmacy technicians has been completed by over 3,000 individuals, enabling them to provide a range of services within GP practices and PCNs, supporting the general practice team and freeing up GP capacity to see patients. The NHS Long Term Workforce Plan states expansion of the Additional Roles Reimbursement Scheme (ARRS) will be carefully managed taking into account additional training of pharmacists, to ensure the growth in workforce is

sustainable, and considers the additional capacity required to staff roles across primary care. As referenced in our submissions, we will also be exploring establishing their roles as supervisors to support future prescribing pharmacist and pharmacy technician workforce growth.

Additionally, increasing designated supervision and designated prescribing practitioner (DPP) capacity is being addressed by providing training for 500 community pharmacy professionals to be become supervisors of learners and 500 community pharmacists to become DPPs by March 2024, further supporting the delivery of this commitment.

The Department acknowledges the Panel's rating that the funding for this commitment at 'requires improvement' and the feedback from stakeholders that whilst funding for the course is positive other pressures also need to be addressed.

As referenced in our submissions, to improve access to healthcare and the career satisfaction of current community pharmacists, NHS England is introducing independent prescribing and broader clinical skills development for community pharmacists through investment from the Pharmacy Integration Programme. As part of a £15.9m, three-year programme of education and training, 3,000 independent prescribing places for pharmacists in community pharmacy and primary care networks and 10,000 module places for clinical examination skills training for community pharmacists have been funded including specialist modules in cardiology, ENT, paediatrics and dermatology. Additionally, Integrated Care Boards are being supported to create local data bases of multi-professional DPPs who could support pharmacists to become independent prescribers. This would make it easier for pharmacists to identify DPPs local to them and demonstrates the finical backing to support this commitment.

The Department acknowledges the Panel's rating for the impact of this commitment 'requires improvement' and we welcome the agreement of the Panel that expanding prescribing capability is likely to have a positive impact on patients as patients will have easier and quicker access to prescribed medicines. We also recognise the challenges reported by stakeholders in the feedback to this report around the challenge of backfill and DPP training and support.

We can assure the Panel, and the sector, that strategies for further increasing access to prescribing supervision and creating a culture where existing pharmacist independent prescribers train to become DPPs and Designated Supervisors as part of their career development are being implemented. This will ensure the NHS is ready to support and mentor the new workforce of independent prescribers from 2026.

The Department is also pleased to note the view of several submissions that the commitment is appropriate, and that the intended aims set out as part of it are needed by the sector. We acknowledge the rating from the Panel that the appropriateness of this commitment 'requires improvement' and the challenges it raises around remaining barriers which it felt had not been addressed. However, the Department does not agree with the Panel's view that the delivery challenges faced make this commitment less appropriate, as is reflected by the stakeholders.

Currently NHS England is building opportunities for community pharmacists to use new independent prescribing skills as part of integrated primary care teams. It is establishing community pharmacy independent prescribing (IP) pathfinders in every ICB which will

test different models and allow for local variation in clinical design and service delivery, responding to local need and the availability of pharmacist prescribers. The Pathfinders will identify ways that independent prescribing can support patient care and support service development. The Pathfinder programme will inform how a commissioning framework could be established to support independent prescribing within community pharmacy.

We will continue to work at addressing the important issues raised in this report as we continue to deliver toward this commitment.

Commitment 8: Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists (Inadequate)

Commitment met	Funding and resource	Impact	Appropriateness	Overall

This commitment is based on a longer commitment set out in CPCF 5-year deal: year 3 (2021 to 2022), published in August 2021:

"As soon as practicable, we will be seeking changes to medicines legislation to enable original pack dispensing and the wider use of hub and spoke dispensing to improve efficiencies and better use of the skill mix in pharmacy teams so that the clinical skills of pharmacists can be directed to helping patients. We will seek to enable these flexibilities within the CPCF as soon as possible."

The commitment appears in the section on regulatory reform, in which the Government also set out to amend regulations governing the operation of pharmacies in the pandemic, and the way in which pharmacies are run and the tasks they carry out. This commitment focuses on ensuring skills in pharmacies are better integrated in the services provided. The PCN and community pharmacy workforce in England comprises registered pharmacists, registered pharmacy technicians (both registered with the GPhC) and pharmacy assistants. Pharmacy professionals work in community pharmacies, in hospitals as part of specialist teams, and deliver clinical services within multidisciplinary teams across PCNs.

The Department notes the Panel's opinion that this commitment is 'inadequate'. Under the Community Pharmacy Contractual Framework (CPCF) 5-year deal 2019 to 2024; and reaffirmed in the Delivery Plan for Recovering Access to Primary Care, the Government committed to seek legislative changes to enable original pack dispensing and the wider use of hub and spoke dispensing to improve efficiencies and better use of the skill mix in pharmacy teams. As outlined in the Government's submission, we have and continue to take action to deliver against these commitments with a view to deliver the legislative flexibility. Given the delays in progress we accept the Expert Panel's assessment that the Government's progress against this commitment is 'inadequate'.

The Report finds the delivery of this commitment 'inadequate', noting the legislation is not yet in place and that it is not clear what the timeline for the legislation's introduction is. As observed by the Panel, progress against the delivery of this commitment has been impacted by the response to the Covid-19 pandemic. As set out in the Department's submission, the Department and Devolved Governments are looking to amend primary legislation concerning who can supervise the preparation, assemble, sale and supply of Pharmacy and Prescription Only Medicines. This follows an earlier programme of work

to clarify and strengthen pharmacy governance and set out the role and responsibilities of statutory pharmacy roles critical to system governance in pharmacy—The Responsible Pharmacist (primary care), Superintendent Pharmacist (primary care) and Chief Pharmacist (secondary care)—legislation was laid before Parliament and entered into force in December 2022.

As part of policy development, the Department has been conducting extensive pre-consultation engagement over the summer with the pharmacy regulators, professional leadership bodies and representatives of the sector to discuss how the current legislation is interpreted and challenges facing pharmacy employers and pharmacy professionals. This work is also looking at non-legislative measures to underpin and support changes to the law including, but not limited to, education and training needs, regulator/professional leadership body guidance etc.

Changing the law is the last step in a process of gaining consensus on what any new rules should look like regarding who should 'supervise' the dispensing of medicines. There have for many years been strongly held, opposing views in the sector and professions on whether these changes should be made. The recently published report from the cross-sector Pharmacy Supervision Practice Group shows significant and sufficient coalescence of views for the Government to move to formal consultation on amending the law around 'supervision'.

Having listened to the Practice Group and wider interested parties the Department is working with the Devolved Governments to conduct a UK-wide consultation in the autumn. Resultant legislation will then need to be approved by Parliament and the Privy Council, before laying the legislation in spring/summer 2024. The Department will also consult with the sector and profession on when the measures should commence, to ensure any amendments to the law enter into force is in a controlled and measured way, providing the profession and employers adequate time to safely and effectively implement the changes.

Due to the delays in delivering the commitment to ***Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists*** we accept the Panel's assessment of the delivery of this commitment. Nevertheless, progress has been made including changes to VAT legislation referenced by stakeholders.

However, we would point to our submitted evidence to assure the panel and the public that the Department is working with regulators, professional leadership bodies and representatives of the sector to discuss and agree what support is required to effectively implement proposals. This work is funded as part of the core function of the Department. We see the funding for this policy and legislative development as distinct from the contracted funding available through the CPCF. So whilst we acknowledge the challenges highlighted in this report regarding the funding to the sector, we do not agree that this means we have inadequate funding to enable the development and proposal of legislative changes in the sector.

Given that we have not progressed the legislative changes, we also acknowledge the Panel's rating that the impact of this commitment is 'inadequate'. We also accept the comment that the delay in realising some of the proposed changes, from factors such

as the response to Covid-19, has unfortunately limited the impact these changes could have for some businesses and pharmacy professionals. The Department also notes the feedback about the possible consequences the timing of any changes might have on the potential and immediate impact achieved if this is not aligned with wider factors such as flu response. Such factors are and will continue to be considered as part of the planning for any proposed changes, and consultations will be run as part of this work to ensure opportunities to feed into the process.

We are pleased to note the recognition of the potential positive impact those changes proposed to date might achieve. "The proposed legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists. This could lead to improved patient outcomes and a more efficient use of healthcare resources".

The Department welcome the Panel's comments noting the intention of this commitment is appropriate. We do not agree with the Panel's criticism that this commitment is overly vague. Given the need to consult with the sector ahead of any proposed changes, as we have been doing through the summer of 2023 on Skill Mix, it would have been inappropriate to be too specific and exacting what changes we would bring at the start of the CPCF when this commitment was made. We do however agree that any changes planned would need to be inclusive of workforce pressures, with work on these areas already in train.

Extended Services

Commitment 9: Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF. (Good)

Commitment met	Funding and resource	Impact	Appropriateness	Overall

The commitment assessed in this chapter was introduced in year one of the CPCF 2019/20 – 2023/24.482 The CPCF 2019/24 shifted the emphasis from dispensing towards the development of clinical services in community pharmacy and the integration of community pharmacy within primary care. The Department welcomes the Panel's overall rating for this commitment as being 'good' along with the positive feedback from stakeholders.

We are pleased to read the feedback supporting the success achieved from the PhIF's piloted and subsequently rolled out services. Community Pharmacy England highlight the numbers who have engaged with these services to date with over 9,000 registered to provide the Hypertension Case-finding Service and over 4,000 registered to provide the Smoking Cessation Service.

The Department acknowledges the Panel's rating of the funding of this commitment as 'requires improvement'. Whilst we would point to the positive feedback that the report references about the funding being adequate, we also note the challenges faced around the transition of funding once the pilot ends. In this context it is worth noting that we have invested an additional £50 million into the CPCF in both 2023/4 and 2022/23 and have announced an investment of up to £645 million to support the delivery of Pharmacy First, which also includes money to support the extensions of the Blood Pressure Checking

Service and Oral Contraception services.

We also acknowledge the Panel's rating that the impact of this commitment 'requires improvement'. The Panel appears to be basing this rating on the lack of published data, overlooking the positive feedback it received at round tables and in submissions, which it references in its report. The Department would like to highlight that any new service is required to go through a rigorous assessment to ensure it is implementable in community pharmacy, effective, safe and will deliver value for money for the taxpayer before it is introduced. This includes engagement with a range of specialist and experts as well as careful analysis of pilot outcomes against these objectives.

Further, in support of the announcement of the Delivery Plan For Recovering Access To Primary Care's commitment to expand the hypertension case finding service in community pharmacy, in May 2023, we published an analysis of its expected impact on the Government's website, which was based on a range of widely available published studies. We are also pleased to read that "many stakeholders provided anecdotal examples of the positive impact of extended detection and prevention services, particularly in terms of improving access to services". Given the pre-launch evaluation of services and the feedback on the success of these services are reported to the Panel, we do not agree with the 'requires improvement' impact rating of the Panel.

We are pleased to note the 'good' rating the panel has given to the appropriateness of this commitment. We are also grateful for the recognition the report provides for the role of community pharmacy and the value its accessibility brings to communities.