Written evidence submitted by the Pharmaceutical Services Negotiating Committee (APE0009)

About PSNC

The Pharmaceutical Services Negotiating Committee (PSNC), soon to be re-named Community Pharmacy England, promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health and Social Care as the body that represents NHS pharmacy contractors (owners). We work closely with Local Pharmaceutical Committees (LPCs) to support their role as community pharmacy's local representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

Responses on the Government commitments under evaluation

Community pharmacy: 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.

PSNC maintains that community pharmacies should be properly and fully funded such that in the majority of cases additional funding is not required to maintain their viability and thus maintain patient access to NHS pharmacy services. And where the population served by the pharmacy is too small for a pharmacy to be financially viable, the pharmaceutical regulations provide that NHS England (NHSE) and now Integrated Care Boards (ICB) may fund *Local Pharmaceutical Services* pharmacies from local budgets, outside the Community Pharmacy Contractual Framework (CPCF) funding sum.

The Pharmacy Access Scheme (PhAS) was maintained with the introduction of the 5-year CPCF in 2019. During a joint Department of Health and Social Care (DHSC), NHSE and PSNC review of the 5-year agreement in 2021, it was concluded that there had been fewer pharmacy closures of PhAS supported pharmacies than those not supported, but at a cost to all other community pharmacy contractors of approximately £20-24m each year from the overall, limited, remuneration sum.

The funding of PhAS pharmacies from other community pharmacy contractors has been and remains a source of significant concern to the sector, particularly during a time of imposed funding cuts and ongoing underfunding, coupled with ongoing workforce and inflationary cost pressures. While the sector was in the past willing to support essential pharmacies funded to a total of approximately £8m per year from its own remuneration, the current PhAS is too much of a burden for the sector to accept, at a total of £20 million each year (prior to 2022, this was £24 million).

Prior to 2022, PhAS funding was based on a top-up to income, to reduce the impact of the 2016 funding cuts. In 2022, it was revised and updated, with funding for eligible pharmacies increasing with dispensing activity to a maximum payment of £17,500 each year, and thereafter decreasing as dispensing volume increased further and the pharmacy (at least in theory) required less funding.

PhAS eligibility is based on distance from the next nearest pharmacy and dispensing volume criteria and since 2022, all eligible pharmacies have received funding. The eligibility criteria and entry to the scheme are fixed until the scheme is next updated. The funding seeks to support pharmacies in rural locations and those in very deprived locations to maintain patient access to NHS pharmacy services in these areas.

The DHSC 2022 PhAS guidance, updated on 12th May 2023, provides a comprehensive explanation of the scheme and a shorter explanation is provided by a PSNC briefing note.

Community pharmacy: 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.

The CPCF negotiations related to the 5-year CPCF agreement have resulted in changes to the distribution model for the overall CPCF funding sum, but we do not consider this to have been an appropriate review of the funding model. When considering the funding of community pharmacies, it is important to distinguish the quantum of funding made available to cover the work the NHS requires contractors to undertake from the funding model used to distribute it.

In the recent round of negotiations on Year 4 and 5 of the 5-year CPCF agreement, NHSE committed to commissioning an economic analysis of NHS Pharmaceutical Services through an independent review, using data provided by contractors, working with PSNC. If completed appropriately, this review should help to inform the negotiation of the future CPCF.

Community pharmacy is a sector in crisis, as demonstrated by the findings of PSNC's 2023 Pressures survey, which sought the views of all contractors and their teams. It has been subject to massive real-terms funding cuts since 2016, at a time when core dispensing and additional services expectations have risen significantly, and the underlying cost base has increased due to inflation and rising employment costs driven by staff shortages. This is described in PSNC's recent analysis of the funding pressures being suffered by the sector. No flexing of the funding model can correct for this; the only solution is an appropriate quantum of funding being made available to the sector.

As we saw during the COVID-19 pandemic, when pharmacies kept their doors open, when most other healthcare providers were working behind closed doors, the importance of maintaining the safe and efficient supply of medicines (the pharmacy dispensing service) is of critical importance to the nation.
With 1.1bn prescription items forecast to be dispensed in 2023/24, this remains a significant proportion of the workload and therefore the costs of providing the community pharmacy service and the funding for this essential service should not be a pot to raid to pay for additional clinical services.

Despite this, the 5-year CPCF removed £200m from funding for dispensing, on the basis that contractors' costs would be reduced through enhancements to the efficiency of the sector which would be provided by regulatory changes to be introduced by DHSC; these regulatory changes and hence efficiency savings have failed to materialise. The funding removed from the dispensing service has been used to fund growth in the provision of clinical services, with contractors now providing increased numbers of these.

Traditionally the role played by funding for services in the overall economics of community pharmacies has been small. Funding for dispensing has had to pay the full costs of operating a pharmacy, many of which are fixed in nature; services have been paid for on a marginal basis, not covering a fair proportion of the overall business overheads of the pharmacy. As the volume of services increases, this model becomes less tenable and we believe there is a need to develop and agree a model with DHSC and NHSE that recognises the interdependence between the different types of activities pharmacies are undertaking for the NHS, and pays for them appropriately, ensuring that sustainable business models exist for contractors.

This places an increased focus on the method by which both the quantum and nature of payments for services are calculated. Services need to be fully costed. Decision making in Government and the NHS needs to be sophisticated enough to allow for the fact that the cost model for pharmacies is fundamentally different to that for other NHS providers, such as general practices. Incentives need

to be embedded within the funding model that drive the commissioner's desired behaviours, funding capacity (the cost of contractors being available to provide the required service), the cost of providing the service and also providing a share of the benefits of good performance by contractors in the funding they receive.

Integrated care (including patient safety): 3. Deliver a new Community Pharmacist Consultation Service with referrals from NHS111, GPs and A&E.

The commitment for DHSC and NHSE to commission the Community Pharmacist Consultation Service (CPCS) was met, with the NHS 111 and general practice referral routes being added in line with the time commitments given. The testing of referrals from urgent treatment centres (UTC) and emergency departments (ED) was delayed, largely due to the impact of the COVID-19 pandemic on hospital trusts and urgent care providers. Referrals from that group of providers commenced on 15th May 2023.

All the referral routes require the referring organisations to undertake development of their processes and systems to be able to make referrals. This may include amendment of standard operating procedures, development of IT systems and in all cases, it will require the training and re-training of staff to ensure referrals are made appropriately and continue to be made over time, as staff turnover and potentially skills degradation (where regular referrals are not part of the day-to-day practice of individual staff members) have an impact on the volume of referrals.

Significant effort was put into supporting the implementation of referrals from NHS 111 by 111 providers, supported by local NHS organisations, LPCs, pharmacy contractors and NHS England. In many areas, the initial support from NHS organisations was not resourced well enough to achieve an optimal level of referrals in a timely manner. Over time, sustained implementation support has led to referrals being made by all 111 providers, but we understand the levels of CPCS referrals across different 111 providers still vary in a way which cannot be explained by variations in the population served. Pharmacy contractors also regularly report patients visiting pharmacies for minor ailments consultations, following the guidance of an NHS 111 health adviser, but where no CPCS referral has been made by NHS 111. That results in the pharmacy contractor undertaking work for which there is no direct funding from the NHS.

Similarly, a large amount of support was required to implement general practice referrals to CPCS at a local level and this continues to be required, as many practices have still not implemented the referral pathway or have implemented it, but it is not optimally embedded in their processes, resulting in lower levels of referrals than might be expected. NHS England did eventually commission more support for general practices to implement the referral pathway, but this arrived later than should have been the case and it lacked the scale that was required for an implementation programme of this size. As a consequence, much of the support to embed GP referrals and to maintain levels over time has been provided by LPCs, as a means of indirectly supporting the local pharmacy contractors they represent.

One of the flaws of the CPCS, from a contractor perspective, is it only provides funding for patients referred to the pharmacy for a consultation. Many patients directly request consultations with a community pharmacist separate from the CPCS, either due to prior experience of the service, which results in them presenting without a referral on future occasions or their prior knowledge that such consultations can be requested at a pharmacy. The ability for patients to walk in to a pharmacy to request support with the management of minor illness is a great benefit to them and to the NHS, as it avoids the use of other primary and urgent care services. However, the CPCF funding does not fully remunerate contractors for provision of advice to these patients.

Following increases in the volume of such requests for support seen during the peak of the COVID-19 pandemic, PSNC submitted a proposal to DHSC and NHSE in March 2022, seeking the commissioning

of a Pharmacy First service, where patients could walk in to a pharmacy for advice, with appropriate funding from the NHS to cover the cost of this work. Our proposal also included the supply of certain prescription only medicines, where clinically appropriate, via the use of patient group directions or independent prescribing by a community pharmacist. Some of this has been reflected within the recently published Delivery plan for recovering access to primary care.

We believe the CPCS has had a positive impact for patients and other NHS providers, however access to data on the provision of the service and its outcomes is not easily available. Initially NHSE commissioned IT systems for pharmacy contractors to use, which also provided for the visibility of service data at both a local and national level. This data was particularly helpful to LPCs in their efforts to support the rollout and optimise its use over time, allowing them to target support, where necessary, for pharmacies and referring organisations.

NHSE subsequently stopped commissioning such IT systems and passed the responsibility, and the cost, to contractors to commission their own systems. This change in policy has meant there is currently no timely access to data on the provision and outcomes of the service. As contractors do submit detailed information on the outcomes of each CPCS consultation to an NHSBSA website, it should be possible for summary data on the service to be made publicly available to support review and development of the service at a local level.

Integrated care (including patient safety): 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 Medicine Service').

The Discharge Medicines Service (DMS) was successfully commissioned, on schedule, by DHSC and NHSE as part of the 5-year CPCF agreement, notwithstanding the ongoing COVID-19 pandemic at the time.

As with the CPCS, this service requires changes in processes and development of IT systems within referring organisations – in this case hospital trusts – in order to identify and refer patients who will benefit from the DMS to their community pharmacy at the time of discharge from hospital.

Many NHS trusts had received support to undertake these changes in processes ahead of the launch of the DMS, via a programme of support from the Academic Health Science Networks (AHSN). However, not all trusts had accessed this support before the end of the AHSN programme and even where trusts had engaged with the support, in many cases, referral levels to the DMS are generally lower than was originally expected. Many LPCs have sought to work with trusts to support the development of their processes and systems to make referrals to the DMS. However, there are still trusts that are not yet making referrals to the service and LPCs report significant variability in the number of referrals being made by similarly sized trusts.

It is difficult to track the progress of the service and the levels of referrals made by trusts, as contractors are currently having to submit a truncated dataset on the service to the NHSBSA, as the development of an application programming interface (API) between community pharmacy IT systems and the NHSBSA has not yet been put in place by NHSE. We believe insufficient priority has been given to the development of these interfaces by NHSE, which is currently reducing the availability of data on the service and it is creating unnecessary additional workload for contractors, as they have to manually submit data on each provision of the service on an NHSBSA website.

The evidence base for this service, from the academic evaluations of pilot services suggests the DMS is highly valuable to patients and to the NHS, including significant improvements in patient safety and the creation of significant health economic benefits to the NHS. It therefore follows that more effort should be invested by the NHS and trusts in increasing the number of referrals to the service. PSNC believes this would be a very sensible development in due course, however at the current

time, where the funding for all CPCF services remains capped by the Government and NHS, we do not believe there is sufficient funding being made available to support such an expansion in provision of the service.

Workforce, education and training: 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.

We are not aware of specific time commitments for implementation of this programme of education and training, but NHSE, working with the former Health Education England, has commissioned a variety of opportunities for community pharmacists. These have included training to support the provision of the CPCS, including patient examination and consultation skills and various clinical skills modules from a range of Higher Education Institutions. Additionally, independent prescribing training has also been made available to community pharmacists via this route.

The latter programme provides access to independent prescribing training for a relatively small number of pharmacists, when considered alongside the large number of community pharmacists who are not currently qualified as prescribers.

To train as an independent prescriber, it is necessary for the pharmacist to have access to a designated prescribing practitioner (DPP). The availability of DPPs is currently a rate limiting step in the number of community pharmacists that can study to become a prescriber. Additionally, the lack of NHS funding in England to support the time a DPP will spend with the pharmacist undertaking prescribing training has also been identified as a significant barrier to increasing the availability of DPPs to participate in upskilling the community pharmacist workforce. Large pharmacy contractors have reported to PSNC that they have a very significant demand from employee pharmacists to train as independent prescribers, but they only have access to a very small number of DPPs able to support the training process.

While the provision of funded education and training programmes to community pharmacists is to be welcomed, solely funding the cost of course fees does not address the wider cost for contractors of providing time during the working day for employees to undertaking the training. The provision of such 'protected learning time' or alternatively paying employees extra to recognise the training they undertake outside of their working hours is not a cost many contractors can currently afford, as a result of the NHS funding cuts they have suffered over several years.

The inability of contractors to be able to afford to invest in the training and development of their staff can reduce the likelihood that they will retain pharmacists and other staff in employment within community pharmacy, particularly with many new roles for pharmacists and pharmacy technicians having been offered over the last few years within Primary Care Networks, funded by NHS England via the Additional Roles Reimbursement Scheme (ARRS). Contractors report losing many staff members to new ARRS funded roles over the last few years, which alongside various impacts on working patterns brought about by the COVID-19 pandemic, have significantly contributed to the current workforce crisis which community pharmacy is suffering. Highlighting this issue, the Hewitt Review: an independent review of integrated care systems recently noted *the national requirements and funding of Additional Roles Reimbursement Scheme (ARRS) roles for community pharmacists within PCNs, has on occasion exacerbated the problem of a general shortage of pharmacists, with some now preferring to work within primary care rather than remain in community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges*.

Workforce, education and training: 8. Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists.

The legislative changes to allow better use of skill mix in pharmacies and enable the clinical integration of pharmacists, envisaged in the CPCF 5-year deal, have been delayed, at least partly due to the COVID-19 pandemic.

The failure of DHSC to deliver the legislative changes to support the promised operational efficiencies in community pharmacy early in the 5-year CPCF has had a major impact on contractors and the success of the deal. Broadly, the sector has delivered on its side of the 5-year deal, including providing the envisaged new services. This issue was examined in the 2021 DHSC, NHSE and PSNC annual review of the 5-year deal.

DHSC's recent update on the CPCF, included a summary of the introduction of legislative and VAT changes, which will facilitate more involvement of the wider pharmacy team in the provision of clinical services.

In addition, discussions on changing the interpretation of pharmacist supervision of non-General Sales List medicine supply will be consulted on this summer. Although the legislative means by which this will be achieved remains unclear and there is concern by some that this change in interpretation may impact interpretations of the meaning already used by some contractors who are using existing technology to assist their dispensing of NHS prescriptions.

Legislative changes around enablers – for example, hub and spoke and original pack dispensing - to assist the sector, remain promised and were stated in the Year 4 and 5 letter of the CPCF 5-year deal.

It remains to be seen whether the introduction of legislation to permit hub and spoke dispensing between two separate pharmacy business will provide any economic efficiencies. It is broadly recognised that hub and spoke dispensing is activity saving by freeing up staff time in the spoke, but it is not accepted that hub and spoke dispensing provides financial savings.

PSNC remains determined to ensure that hub and spoke dispensing between separate legal entities is such that dispensed medicines are supplied to the patient from the spoke pharmacy, for safety and market entry control reasons. Further information on this is set out in our response to the DHSC consultation.

In addition and recognised by DHSC in its consultation under the Medicines and Medical Devices Act 2021, it remains important that the introduction of hub and spoke legislation is voluntary, and the legislation is permissive. There may be economic reasons why contractors choose not to make use of any new legislation. Other 'levers' in the CPFC must not be used to contradict this commitment from DHSC, and, for example, funding arrangements for the sector must not be used to make such methods of dispensing effectively mandatory.

With regard to original pack dispensing, while changes to UK legislation may be relatively straightforward, it is important that the financial risks around NHS OPD dispensing are not borne by contractors and that again contractors are given an option to make use of the legislative changes or not, if patients and the pharmacy wish to continue to give a patient their full allocation of the prescribed item. This may be particularly important for patients who pay the NHS prescription charge for dispensed medicines.

The impact of any of these planned changes – on skill mix and other enablers - on the CPCF 5-year deal is likely to be minimal given that the changes are either late in the day or are yet to be achieved, but they may assist the sector in future years.

While the sector is very disappointed with the delays around the introduction of the promised efficiencies, there is recognition of the pressures DHSC has been under, particularly with the COVID-19 pandemic. It is though disappointing in the extreme that there has been no additional funding to support contractors delivering their side of the deal. As stated earlier, this issue was explored further in the 2021 annual review of the CPCF by DHSC, NHSE and PSNC.

Extended services: 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.

As part of the 5-year CPCF agreement, three services have been piloted and then introduced into the CPCF within this area: the Hypertension Case-finding Service; the Smoking Cessation Service; and the Pharmacy Contraception Service.

Pharmacy contractors have engaged well with the first two services, with over 9,000 registered to provide the Hypertension Case-finding Service and over 4,000 registered to provide the Smoking Cessation Service. However, as with the CPCS and DMS, the Smoking Cessation Service relies on developments within other NHS providers and changes to processes to make referrals to the service which pharmacy teams can act upon. The number of referrals to the service has been relatively small, as a consequence of the gradual rollout of the underpinning Ottawa Smoking Cessation model in hospital trusts across England, the progress of which is likely to have been delayed by the impact of the COVID-19 pandemic on trusts.

The Pharmacy Contraception Service has only recently commenced and PSNC has protested its rollout at this time, as we do not believe there is sufficient funding within the CPCF sum to allow this service to be provided by contractors, in addition to the existing CPCF services.

Within the recently published Delivery plan for recovering access to primary care, DHSC and NHSE have committed to provide additional funding to support the expansion of the Pharmacy Contraception Service and the Hypertension Case-finding Service in 2023/24 and 2024/25, however this is subject to negotiations with PSNC, which have recently commenced. Until those negotiations are completed, it will not be possible to determine whether the additional funding will be adequate to support any expanded provision of the services.

NHSE has undertaken evaluations of the pilots of the three services, but the evaluation reports have not been published in full. We are unsure of the reasons for this decision and we would ordinarily expect such reports to be published to help inform the rollout of the substantive services and the development of future policy on community pharmacy services.

As with the DMS, APIs to support the submission of data on the Hypertension Case-finding Service and the Smoking Cessation Service to the NHSBSA have not yet been developed by pharmacy IT system suppliers and the NHSBSA. System suppliers are reliant on NHSE taking actions to support these developments, with the publication of technical specifications, before they can undertake these developments.

We believe insufficient priority has been given to the development of these interfaces by NHSE, which is currently reducing the availability of data on the two services and it is creating unnecessary additional workload for contractors, as they have to manually submit data on each provision of the service on an NHSBSA website.

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