Written evidence submitted by the Company Chemists' Association (CCA) (PHA0045)

Company Chemists' Association
The CCA is the trade association for large pharmacy operators in England, Scotland and Wales. Our membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 5,500 pharmacies, nearly half the market.

The CCA's written evidence
The CCA welcomes this timely inquiry. Our responses are from a community pharmacy perspective. We would welcome the opportunity to be called to give oral evidence to the Committee.

Executive Summary

- The government's funding arrangements for community pharmacy are not fit for purpose.
- Real-terms funding has been cut by 30% since 2015. There is currently an annual funding shortfall of at least £67,000 per pharmacy in England.
- After more than four years of the current five-year contractual framework, the government has yet to deliver on any of the 'efficiencies' that were intended to enable the transition of funds from medicines supply into clinical care services.
- Since 2015 720[1] pharmacies have permanently closed, with a disproportionately high number closing in the 20% most deprived parts of England.
- We want to see a more clinical future for pharmacists and community pharmacy. However, this requires a clear vision, a fully costed roadmap for change and coordinated, ambitious, NHS commissioning.

1. What does the future of pharmacy look like and how can the Government ensure this is realised?

The future of pharmacy will contain a far greater role in delivering essential urgent care, long term condition management, screening and administering vaccinations. Our modelling estimates[2] that, each year, community pharmacies could free up 42m+ GP appointments[3], screen 5m+ people with undiagnosed hypertension, reduce hospital readmissions by at least 65,000 and release 2m bed days.

Realising this future, requires additional investment (see Q5). The NHS must also commission services ambitiously and nationally, to ensure pharmacy businesses have the confidence to invest and to avoid 'postcode lotteries' (see Q9).

Holistic workforce planning for primary care, together with a roadmap to harness Pharmacist Independent Prescribers (PIPs) and upskill existing pharmacists to become PIPs (see Q2) is required too.

Between 2017/18 and 2022/23, patient 'touchpoints'[4] between community pharmacists and patients through nationally commissioned clinical services alone rose from 5.7m to over 10m. This

[1] CCA, 1,000+ pharmacies and GP practices in England have permanently closed since 2015, February 2023.
[2] CCA, CCA prospectus – a future for community pharmacy, February 2023. Our modelling builds on existing practice and the sector's track record of delivery.
[3] This includes: an ambitious Pharmacy First service (freeing up 30.5m urgent and same-day GP appointments), 10m vaccination and 2m contraception appointments.
[4] A 'patient touchpoint' is defined as an occasion where there is a pharmacist-patient interaction. The following data sources were used to estimate the number of touchpoints associated with national clinical services, between 2017/2018 and 2022/2023:

- New Medicine Service, Medicine Use Review, Appliance Use Review, Stoma Customisation, Community Pharmacy Consultation Service, Hepatitis C testing, Blood Pressure Checks, Ambulatory Blood Pressure Monitoring, Smoking Cessation consultations: NHS BSA, Pharmacy and appliance contractor dispensing data, March 2017- February 2023. *At the time of writing data for March 2023 was not yet available and is based on estimates.*
- Discharge Medicine Service: NHS BSA, Discharge Medicine Service, March 2021- February 2023. *At the time of writing data for March 2023 was not yet available and is based on estimates.*
- Flu vaccines: PSNC, Flu Vaccination – Statistics, September 2017- March 2023.

trend will continue as pharmacies are commissioned to deliver further NHS services and an increasingly clinical future is realised.

It is important to note however, that the safe and effective supply of medicines will always remain a core part of community pharmacy's role in the country's healthcare system. Community pharmacies dispensed 1.075 billion[5] items prescription items in 2022/2023, around 94 million (10%) more than in 2014/15. Despite nearing the end of the current Community Pharmacy Contractual Framework (CPCF) 2019-24, progress on the 'efficiencies'[6] committed to has been disappointing and must be realised.

Unfortunately, due to significant cost pressures, the medicines supply chain continues to experience shocks and needs urgent attention to ensure it is fit for purpose as well as a revision to the associated margin[7] available to pharmacies which has not changed since 2014 (see Q6).

2. What are the challenges in pharmacy workforce recruitment, training and retention, and how might these best be addressed?

The CCA has previously highlighted[8] the critical shortfall of community pharmacists in England. The shortages are caused by a range of factors[9], and evidenced by significant increases in recorded locum rates which have doubled since 2020[10]. One of the main factors causing the shortages seen is the Additional Roles Reimbursement Scheme (ARRS)[11]. Since 2020 Primary Care Networks (PCNs) have been able to use ARRS money to recruit pharmacists (and pharmacy technicians) from hospitals and the community setting. To date 8,000 pharmacists[12] have moved into newly created roles. The funding for these new positions was released without sufficient consideration of the impact they would have on other parts of the NHS.

We are pleased to see the recent NHS workforce plan[13] recognises the need to train more pharmacists. Whilst it also announced an extension of the ARRS scheme, NHSE did commit to carefully manage the impact of the funds, and consider additional training of pharmacists, to ensure the growth in workforce is sustainable. We recognise that this may prevent the currently very bad situation from getting much worse, it does little to repair the damage already created.

Instead of using the ARRS funds to move healthcare professionals from one, easily accessible, setting to another, with significant challenges of space and accessibility, we believe the funding can be better used to provide care for patients in community pharmacies. PCNs and GPs should be allowed

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[5] Dispensing data between April 2017 and February 2023 can be accessed here: NHS BSA, Pharmacy and appliance contractor dispensing data. *At the time of writing March 2023 was not yet available and is based on estimates.*

[6] The 2019/20 – 2023/24 Community Pharmacy Contractual Framework (CPCF) committed to rolling out efficiencies – including legislative change to allow pharmacies to benefit from more efficient hub and spoke dispensing, exploring and implementing the greater use of original pack dispensing, proposing legislative changes that will allow for better use of the skill mix in pharmacies and exploring changes to funding and fee structures – see DHSC, NHSE and PSNC, The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan, July 2019.

[7] As part of the Community Pharmacy Contractual Framework, the sector will receive £2.592bn per year from 2019 to 2023/24. Of the annual sum, £800m is to be delivered as retained buying margin – in other words, the profit pharmacies can earn on dispensing drugs through cost-effective purchasing. More information via Community Pharmacy England Retained margin (Category M)

[8] Written evidence submitted by The Company Chemists' Association (RTR0158) to the Health and Social Care Committee's inquiry into workforce recruitment, training and retention in health and social care, July 2022.

[9] In 2022, the CCA estimated (see CCA, Review of the Community Pharmacist Workforce in England, January 2022) that there was a shortfall of 3,000 community pharmacists in England, caused by changing working patterns, high vacancy rates among pharmacy support staff and Primary Care Network (PCN) recruitment of pharmacists. Changing workforce patterns (increased part-time working, reduced working hours and greater portfolio working mean that more pharmacists are required, in headcount terms, to meet patient demand. The average number of pharmacists by headcount per store rose from 1.97 in 2017 (HEE, Community Pharmacy Workforce Survey 2017, 2017, see page 15) to 2.43 in 2021 (HEE, Community Pharmacy Workforce Survey 2021, 2022, see page 22), a difference of 0.46. There are also growing vacancy rates among support staff (the HEE Community Pharmacy Workforce Survey 2021 found that headcount vacancy rates for certain roles were as follows – accuracy checkers (19%), trainee medicine counter assistants (17%), trainee dispensing assistants (13%), medicine counter assistants (12%))

[10] In England, locum rates increased by 90% between January-December 2020 (see Locate A Locum, Annual Locum rates report, 2022) and July-September 2022 (see Locate A Locum, Locum rates study 1st July – 30th September, November 2022)

[11] The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 as a key part of the government's manifesto commitment to improve access to general practice. Through the scheme, Primary Care Networks (PCNs) can claim reimbursement for the salaries (and some costs) for 17 new roles within the multidisciplinary team. This includes clinical pharmacists and pharmacy technicians.

[12] CCA, CCA workforce review – the Community Pharmacy Workforce Crisis: One Year On, May 2023.

[13] NHSE, NHS Long Term Workforce Plan, June 2023. The plan commits to expand training places for pharmacists by 29% to around 4,300 by 2028/29. It notes that "This will put us on the path to increasing training places by around half overall to almost 5,000 by 2031/32. The number of pharmacy technicians will also grow in future years". Later, it announces the expansion of ARRS but adds "This expansion would 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".

to use ARRS funds to commission pharmacies to deliver 'packages of care', such as Structured Medication Reviews.

Some of the retention challenges facing the sector are caused by the current paucity of funding. Pharmacies have had to cut costs in order stay afloat, often by reducing headcount. The reduction in staffing levels places increased pressure on the remaining team. The current funding shortfall (see Q5) can be addressed through ambitious NHS commissioning. Knowing what opportunities there are to earn money, how much money and for how long, will give pharmacies greater certainty to invest in staff, training, and infrastructure. Ambitious commissioning will generate a virtuous circle, as the ability to earn will generate the confidence to invest, generating further capacity to provide additional patient-facing care.

Policymakers must also provide a roadmap for harnessing the potential of Pharmacist Independent Prescribers (PIPs). From 2026, all new pharmacists will become independent prescribers at the point of registration. Again, ambitious commissioning is essential if this new pool of clinical skill is to have the biggest impact on the health of the nation.

Data shows that currently only 5%[14] of community pharmacists have Independent Prescribing qualifications. Robust plans for training the existing pharmacists workforce, to become PIPs, is also required, to avoid creating a two-tier workforce.

We encourage efforts to develop the role of pharmacy technicians and welcome recently announced VAT changes[15] and changes to service specifications which will allow technicians to play a greater role in the delivery of the smoking cessation and hypertension services. We would like to see technicians added the list of professionals who can work under a Patient Group Direction.

Making changes to service specifications, regulation, and NHS Terms of Service would allow the skills of Pharmacy Technicians to be applied differently, and would create essential additional capacity. This could be used to enhance the impact of PIPs. Currently staffing levels often mean that pharmacists spend most of their time delivering operational dispensing activities. This limits the time available for them to deliver clinical services for patients.

Pharmacists are also 'tied' to operational tasks by outdated legislation (commonly referred to as 'supervision'). The Government should implement changes to supervision, freeing up pharmacist time to provide patient-facing care, as well as other efficiencies (see Q1) committed to as part of the current CPCF.

3. To what extent are digital systems used in pharmacy sufficiently interoperable with those in general practice and hospitals?

Currently, the level of digital interoperability is severely hindering the ability of pharmacy teams to do more for patients and the NHS. Some clinical activity, such as the administration of flu vaccinations, can be entered into patient records, using Professional Records Standard Body (PRSB) data standards. We would like to see this further developed and expanded so that more of community pharmacy's service outcomes can be entered into the patient record. This would allow clinicians access to the information they need so they can deliver care in a seamless and frictionless way to the patient.

[14] Community Pharmacy Workforce Development Group, A review of the community pharmacy workforce: 2021 and beyond, June 2021, see page 11
[15] The Spring Budget announced that the VAT treatment of medical services carried out by staff directly supervised by pharmacists will be exempt from 1 May 2023 – further detail here.

Work is progressing well to integrate pharmacy systems through GP connect and the Booking and Referral Standard[16] (BaRS) which should transform community pharmacy practice. Once these two tools are in place, the opportunities afforded by community pharmacy commissioning will greatly increase.

Whilst these will help with the immediate future, they are just a first step in a journey towards wider transformation. Ongoing efforts to drive improvements in the Electronic Prescription Service (EPS) and longer-term plans for integration must continue.

Recent innovations with both the NHS app and the National Booking System (NBS) have led to exciting new access to patients. It is important that the systems reflect existing digital infrastructure and are flexible to allow for innovation for partners across the healthcare landscape. Both the systems must allow seamless integration with existing software. National standards would allow NHS and private innovation to work together for patient benefit.

4. What innovations could have the biggest impact on pharmacy services and why?

Independent Prescribing will have the single greatest impact on pharmacy services. It will allow pharmacists to prescribe autonomously for any condition within their clinical competence. Investment in this change to pharmacy professional practice is crucial to enabling further evolution. However, there appears to be no real roadmap for implementing this change. There must be clarity as to when, and how, pharmacists will prescribe within the NHS – so that professionals can commit to training, and pharmacies can make the preparation and investment needed. Without this, there is a risk that there will be very few prescribing roles in community pharmacy meaning registrants from 2026 will prioritise other settings, where their full skillset can be used.

Better use of the skill mix and 'supervision' changes would allow other members of the pharmacy team to take on additional responsibilities and pharmacists to dedicate greater time to patient-facing care which would boost capacity and capability. Enabling a framework for supervision will allow pharmacists to ensure patient safety is maintained, whilst focusing their time on direct patient care (see Q2).

DHSC has already consulted on changes to 'original pack dispensing', yet these changes have not been implemented. Current practice requires manual 'splitting' and 'snipping' of strips of tablets to ensure the quantity meets legal requirements of the prescription. Allowing original pack dispensing could affect 6% of prescription items (62m) a year, reducing workload, reducing wastage and increasing efficiency in pharmacy teams. It may also support greater use of automation. Legislative changes, however, must be combined with changes to funding[17].

Technicians should be added to the list of professionals who can work under a Patient Group Direction without delay (see Q2).

Unfortunately, we do not think that legislative changes related to hub and spoke dispensing across legal entities will not yield the efficiencies envisioned by DHSC. Hub and Spoke assembly and supply, whether internal or across legal entities requires significant capital investment, which may not be possible given the current financial pressures facing the sector.

[16] The Booking and Referral Standard (BaRS) is an interoperability standard for healthcare IT systems that enables booking and referral information to be sent between NHS service providers

[17] Currently pharmacy teams spend significant time 'splitting' and 'snipping' original packs of medicines in accordance with a prescription. This is particularly an issue with repeat medicines. For example, a patient may be prescribed 28 tablets but the manufacturer's original pack provides 30. The patient would use the 30, as it is a repeat medicine for a long-term condition but the NHS only pays for the 28. Pharmacies can legally only supply patients with 28 tablets and will only paid as such, meaning they have to open the pack and 'snip' two tablets out which would in all likelihood be given to the patient later on. The NHS currently has no system to allow pharmacist to supply any quantity other than that prescribed nor has it agreed additional funding for the extra tablets if they were to supplied to avoid the inefficiency of 'snipping'. Legislative therefore needs to be combined with changes to funding if these proposals are to benefit patients.

5. To what extent are funding arrangements for community pharmacy fit for purpose?

Funding arrangements are not fit for purpose. The contractual framework, as well as the funding model which underpins it, need urgent reviewing. In September 2022[18], NHSE committed to commission an economic analysis of NHS pharmaceutical services through an independent review to help inform the negotiation of the future contractual framework. Unfortunately, this review has not begun yet.

Under the current CPCF (2019/20 – 2023/24), the Government agreed to a fixed annual sum of money (£2.592bn). However, this fixed amount of money was agreed for an unknown (but rising) quantity of work. The transition of funding from supply and toward the delivery of new clinical services, was predicated on efficiencies the DHSC committed to rollout, but which are yet to be delivered (see Q1).

The funding for pharmacy, recently announced in the primary care recovery plan is welcome, but it is new money for new work. Unfortunately, it fails to address the historic funding black hole[19]. The current annual funding shortfall is at least £67,000[20] per pharmacy in England. Since 2015, there has been a 30% real-terms cut[21] in funding and our most recent analysis[22] (February 2023) shows that 720 pharmacies have permanently closed, 41% of those in the 20% most deprived parts of England. This figure will, unfortunately, have risen since.

Pharmacies should also be granted further opportunities to earn income outside of the contractual framework. When there is funding behind workload demand (e.g. the flu and Covid-19 vaccination programmes), the sector has shown it can deliver at scale and on time.

6. What factors cause medicine shortages and how might these be addressed in future?

Between 2014-19, 60%[23] of global shortages were due to manufacturing and quality issues, including shortages of materials and suspension of production because of quality issues and technical problems.

Two of the recent shortages, for Penicillin V and Hormone Replacement Therapy (HRT) products, were caused by unexpected spikes in demand which ultimately led to other lines being affected[24].

A lack of return on investment is one of the root causes of fragility. The margins available on most generic medicines are now so small that businesses cannot risk investing in increased production, to meet temporary demand spikes, as they are unlikely to ever recover the additional costs incurred.

Each year, pharmacies in England are allowed to collectively earn £800m of 'retained buying margin' from purchasing medicines for the NHS. The current level of allowable margin was first agreed in 2014, but has not been reviewed since. Meanwhile, the purchase cost of medicines supplied by pharmacies has increased by 9%. Fluctuations in demand and supply mean that the price pharmacies

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[18] DHSC and NHSE, Community Pharmacy Contractual Framework 5-year deal: year 4 (2022 to 2023) and year 5 (2023 to 2024), September 2022

[19] In 2016, the value of the Community Pharmacy Contractual Framework (CPCF) was cut by around £200m a year and it has remained a flat cash settlement ever since. The current CPCF, agreed in 2019, has not been adjusted despite the Covid-19 pandemic, spiralling inflation and rising cost of doing business ever since. A 2020 report by EY found that 40% of large pharmacy chains sampled are running at a loss – see EY, The business impact of pharmacy registration fees on registered pharmacies in Great Britain, January 2020.

[20] CCA, Funding gap in England equates to more than £67,000 per pharmacy, January 2023

[21] Community Pharmacy England, Information for politicians

[22] CCA, 1,000+ pharmacies and GP practices in England have permanently closed since 2015, February 2023.

[23] OECD, Shortages of medicines in OECD countries, OECD Health Working Papers No. 137, March 2022

[24] This followed reported outbreaks of Step A infections in the US and celebrity television coverage of menopause in the UK respectively ('The Davina effect'). Pharmacies, wholesalers, and manufacturers did not foresee these triggering events and so had not made plans to meet the ensuing increase in demand. The shortage of just one medicine, Penicillin V 125mg/5ml solution, in the case of the Step A outbreak in 2022, meant that prescribers shifted to other antibiotics, placing unexpected pressure on the availability of those lines too. Eventually there were shortages across a whole range of antibiotics. Normally such shortages are temporary as stocks are moved around to match demand.

must pay for medicines can be vastly different to that set in the Drug Tariff, meaning medicines are often supplied at a loss, leading to pressures on cashflow.

A dynamic medicines reimbursement margin is needed to reflect the changing costs and volumes of medicines procured. Moreover, Serious Shortage Protocols (SSPs), originally designed for the UK's departure from the EU, were a useful short-term tactical measure but there is a need for long-term solutions that use the skills of pharmacy businesses and meet the needs of patients and prescribers.

Drug Tariff changes initially proposed before the pandemic should be revisited too. Additionally, a wholesale review of Government action to make the supply chain more robust in the long term is required and should involve all parts of the supply chain.

7. To what extent does community pharmacy have the resource and capacity to realise the ambitions in DHSC's Primary Care Recovery Plan?

Chronic underfunding (see Q5) and workforce shortages (see Q2) mean that delivery will be harder, but we are nonetheless confident that the sector will realise the Plan's ambitions.

Pharmacies will not be able to earn against the funds announced in the plan until the existing services are expanded or the new ones are designed and commissioned. We are very clear however, that while the opportunity to earn new money, through the delivery of new services, is welcome it does nothing to address the underlying cost pressures facing the sector.

An uplift to core CPCF funding, ambitious commissioning of new services and additional opportunities to earn income outside of the CPCF are needed to sustain the community pharmacy network. These changes would also drive greater confidence, allowing investment and creating greater capacity in primary care.

Current Government plans for Pharmacy First will free up 6m+ GP appointments. However, we estimate[25] 30m+ GP appointments, could easily be freed up through an ambitious Pharmacy First service.

Holistic workforce planning for primary care is needed to ensure resources are directed according to patient need (see Q2).

8. Are there the right number of community pharmacies in the right places, and how can we ensure that is the case across the country?

The current level of funding for pharmacy cannot sustain the network as it is. If it could we would not have seen close to 1,000 closures in recent years. Another indicator of insufficient funding can be found in the Pharmacy Access Scheme (PhAS) supports patient access where it may not otherwise be financially viable. Approximately 13% of pharmacies, almost 1 in every 8, are eligible for the PhAS - if so many pharmacies need access to financial support, there is likely to be a problem with core funding. It is also worth noting that the PhAS itself is no guarantee of financial security. 22 pharmacies on the 2017 PhAS list closed, and a further 18 have closed since the list was reviewed in 2022[26]. If the scheme to ensure access to pharmacies cannot deliver, then there must be a bigger problem with funding.

[25] CCA, Pharmacy First and Independent Prescribing, June 2023
[26] CCA analysis of pharmacy data (downloaded as the eDispensary files) from NHS Digital's Organisation Data Service.

Irrespective of PhAS, we are extremely concerned in the overall decline in access to community pharmacy. The 'positive pharmacy care law', whereby access to community pharmacy rises in areas of higher deprivation, is under threat[27]. Our most recent analysis (February 2023) shows that 720 pharmacies[28] have permanently closed since 2015, 41% of those in the 20% most deprived parts of England.

A review[29] of the current mechanism (Pharmaceutical Needs Assessments, or PNA[30]) of controlling entry highlights extreme variation in their design, scope, and conclusions. There is no consistency in the number of pharmacies deemed necessary to meet local pharmaceutical need. There is also a lack of guidance for which variables should be considered, nor how this is measured. Even within a single PNA footprint the number of pharmacies can vary by as much as 50%, (18 per 100,000 to 28 per 100,000) but in each case the conclusion is that the current level is correct.

Furthermore, between 2015/16 and 2021/22, the number of bricks and mortar pharmacies reduced by 673, whilst the number of Distance Selling Pharmacies (DSPs)[31] rose by 247. Analysis[32] shows that 72% of DSPs are operating in breach of spirit of their NHS contracts, and thus restricting local face-to-face access to care. The NHS must audit all 'pseudo'-DSPs and ultimately revoke contracts from those failing to fully meet their contractual obligations.

There is a need to holistically consider pharmacy access, especially considering rising demand for primary care, with particular regard to the access under threat in deprived communities. Moreover, the contractual framework, and the funding model which underpins it, must be reviewed and rethought. Unless the pharmacy contractual framework is financially viable, access will deteriorate further.

9. To what extent are commissioning arrangements for community pharmacy fit for purpose?

Nationally commissioned services (e.g., the flu vaccination programme) often work well, creating efficiencies of scale and enabling large patient-facing marketing. Each year since commissioning, pharmacy has surpassed the previous year's total, now vaccinating 5m+ patients in a single year. Similarly, the Covid-19 vaccination programme (a national enhanced service) has met its objectives within the confines of supply chains. Unfortunately, local variation in process has increased the administrative burden, reduced the efficiency, and ultimately reduced the total potential of the service.

Even when commissioned nationally, services reliant on referrals into pharmacies fail to meet their potential. For example, in 2021/22 there were 700,000 patients referred via the Community Pharmacist Consultation Service (CPCS)[33] – a fraction of the 20m[34] GP appointments the NHS estimate could be transferred into pharmacies. This is roughly the equivalent of one CPCS referral per pharmacy per week.

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[27] Whilst access to healthcare tends to be more limited where there is greater need, the "inverse care law" (see The inverse care law, Hart, The Lancet, Volume 297, Issue 7696, P405-412, 1971), the reverse has traditionally been true in community pharmacy(see The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England, Todd et al, BMJ open Volume 4 Issue 8), where access is higher in areas of greater deprivation (the 'positive pharmacy care law'). We are extremely concerned that this access is now under threat. Recent closures have been skewed towards the most deprived communities and 41% of closures in the last 7 years have been in the 20% most deprived communities (see CCA, 40%+ of pharmacy closures in last seven years have occurred in the 20% most deprived parts of England, October 2022).

[28] CCA, 1,000+ pharmacies and GP practices in England have permanently closed since 2015, February 2023.

[29] CCA, Review of Pharmaceutical Needs Assessments, forthcoming

[30] A Pharmaceutical Needs Assessment (PNA) is an assessment of local pharmacy provision to meet the needs of a local area.

[31] Distance Selling Pharmacies (DSPs) are intended to provide medicines to patients remotely, for example by post or by courier. DSPs are contractually obligated to promote their services and deliver prescriptions across the whole country, rather than choosing to only market and provide their services to patients in their local area. Unfortunately, 72% of DSPs are operating in breach of their NHS contract and over 70% of DSPs dispense more than 50% of their prescriptions to patients from a single postcode area located within 10 miles of the pharmacy. One pseudo-DSP, which receives 99.9% of its prescriptions from a single postal area (and less than 0.04% of items from further than 10 miles away), is in the same postcode as seven local pharmacy closures. DSPs cannot offer the face-to-face medical attention required for patients who are older or digitally deprived. However, a traditional pharmacy offers face-to-face contact to patients in deprived communities and those who are digitally deprived.

[32] CCA, The impact of pseudo-distance selling pharmacies, forthcoming paper

[33] CPCS, which relies on referrals from GP practices or NHS111, connects patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy. More detail can be found at NHS England, NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care

[34] The Pharmaceutical Journal, Around 20 million GP appointments could be transferred to community pharmacy, says NHS England primary care boss, June 2019

Similarly, the Discharge Medicines Service (DMS)[35], experiences significant geographic variations[36] in uptake, despite one in every 23[37] DMS consultations at a pharmacy preventing one readmission in hospital.

There is a lack of emphasis on implementation. Recent commissioning arrangements rely on local implementation, which falls on a pressured workforce in an allied sector (hospitals, GPs, etc.). The focus should instead be on maximising the accessibility of community pharmacy – best achieved by allowing pharmacies to identify patients and allowing patients to 'self-refer'. Pharmacies should be empowered to recruit and market directly to patients just as they do with the flu vaccination programme.

Local pharmacy services, while meeting important patient needs, are often complex and inefficient. For example, disparate local government commissioning of Emergency Hormonal Contraception, has introduced inequity of access and a postcode lottery. There is no common offer for a national patient need, leading to patients going without care. ICSs may offer an opportunity to standardise contracts across large geographies, maximising efficiencies and improving patient awareness.

To improve commissioning, the NHS needs to identify bespoke local needs that warrant local commissioning, but otherwise look to leverage the scale of the sector through national commissioning. Even where commissioned locally, commissioners should use national templates to avoid duplication of effort in stretched NHS commissioning teams. Additionally, when local services become commissioned by a majority of the country, the NHS should aim to adopt these as national services. Finally, the NHS must move away from its reliance on small-scale pilots followed by limited commissioning which invariably introduces postcode lotteries. A lack of standardisation prevents patients from expecting a common set of NHS services wherever they may be. NHS commissioning must be quickly scalable and national to avoid this.

NHS commissioning needs to be ambitious, tied to clear public targets, implementation support and timescales, as well as recognising and sharing of best practice, if it is to deliver widespread patient benefit.

[35] The Discharge Medicines Service is an essential service and thus must be provided by all community pharmacy contractors. Hospitals refer patients to community pharmacy on discharge with information about medication changes made in hospital. The service has been established to: ensure better communication of changes to a patient's medication when they leave hospital and reduce incidences of avoidable harm caused by medicines.
[36] In the first year of the service (March 2021 to Feb 2022 – see NHS BSA, Pharmacy and appliance contractor dispensing data, March 2021 – February 2022), Cheshire and Merseyside had 168 completed DMS consultations per 10,000 population. In comparison, three 3 ICS areas had completed less than 1 DMS per 10,000 population. If all ICSs had performed at the level of the highest performing ICS, there would have been a five-fold increase in patient benefit – by avoiding over 29,000 hospital readmissions at 90-days (see Thayer N, Mackridge A, and White S (2023) Predicting the potential value of the new discharge medicines service in England. Journal of Pharmaceutical Health Services Research, 2023; rmad020).
[37] NHS England, Liverpool's Discharge Medicines Service, May 2022