Supplementary written evidence submitted by Community Pharmacy England (PHA0060)

Introduction

1. Community Pharmacy England is the representative of the approximately 10,800 community pharmacies in England. We are recognised by the Secretary of State for Health and Social Care as the body that represents NHS pharmacy owners.

2. We represent community pharmacy businesses of all sizes in England and are responsible for negotiating the NHS Community Pharmacy Contractual Framework (CPCF) under which all community pharmacies operate.

Executive Summary

3. Community pharmacies play a vital role in dispensing medicines, providing expert health advice and care, treating minor ailments, offering vaccinations and supporting good health – all without the need for appointments.

4. But pharmacies are now facing unsustainable operational and financial pressures as since 2016, the funding received by community pharmacies has declined by 30% in real terms. This funding squeeze has been accompanied by inflationary pressures and workforce shortages which have also driven up costs.

5. Pharmacies are uniquely placed to deliver public health services due to their accessibility and location, with 80% of the population within a 20-minute walk of their local pharmacy and twice as many pharmacies in more deprived areas. As well as being located in the heart of the community, pharmacy staff often reflect the social and ethnic background of their residents and are often the public's first, and sometimes only, point of contact with a healthcare professional. All of this underlines their ability to reduce health inequalities in line with the 20CorePlus5 ambition of NHS England as set out in the NHS Long Term Plan.

6. Community pharmacy could continue to grow its role in delivering clinical care in every neighbourhood and reaching all parts of the population, reducing pressure on GPs and other NHS services. But in order to do so there needs to be a stable, long-term sustainable funding commitment which will enable pharmacies to invest for the future. It is vital that this happens to help reduce some of the critical and existential threats facing pharmacy businesses.

7. This means a fundamental review of the Community Pharmacy Contractual Framework (CPCF) with alignment of care pathways and incentives within the wider primary care system.

8. We are encouraged by the *Delivery plan for recovering access to primary care* published in May, which looks to invest further in community pharmacies to extend the services they can offer. This will not address all the underlying funding issues, but it is a vote of confidence on which we hope to build, for instance to see pharmacies becoming the home of NHS vaccination services and developing other service offers in the areas of prevention and public health, long-term condition management, and women's health.

9. Community pharmacies also urgently need a workforce fit for the future. While the NHS Workforce Plan references to community pharmacy are encouraging, we do need

assurances that mistakes regarding the lack of planning for the impact of the Additional Roles Reimbursement Scheme policy will not be repeated.

10. Work to alleviate medicine supply issues must also be a priority for Government. Alongside reform of Serious Shortage Protocols, we want to see generic substitution implemented to help pharmacists to manage shortages. The concession pricing system also needs reform and we are calling for a strategic review of medicine supply and pricing and a shift in focus with DHSC focused on how to improve the functioning of the supply chain rather than solely on the drive to depress prices and margins.

11. Pharmacy owners should be enabled to better manage their costs, particularly with the current inflationary pressures they are facing. They are unable to charge NHS patients for medicines and treatments (pharmacies collect the prescription charge on behalf of the Government), so there is no way to pass on their additional costs to consumers. Allowing pharmacy owners to make changes to opening times or to reduce their opening hours, to reduce spiralling staff costs, provided that these are notified appropriately to patients and the public, would be one way to help them become more financially sustainable. The current funding levels are not sufficient to maintain all the current opening hours for English community pharmacies.

Evidence from Community Pharmacy England

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

12. Since the pandemic the public have increasingly relied upon community pharmacies as an accessible health resource and demand for help and advice has continued to grow. At the same time the pharmacy contract has introduced a number of new clinical services which have established a wider role for the sector meeting patients' needs.

13. In the immediate future, a new Common Conditions Service – as we are currently negotiating with DHSC and NHS England – should help patients gain easier and greater access to minor ailments treatments, closer to home. We are negotiating how the funding for this will be delivered to ensure that community pharmacies have the core capacity to meet patient needs and deliver completed episodes of care.

14. There is so much more that community pharmacy could offer. We hope that the upcoming NHS vaccinations strategy will make the most of pharmacies – our flu vaccination figures continue to rise (up to 5 million last season), and we have delivered more than 30 million COVID vaccinations from just a small part of our network. Patient satisfaction with pharmacist vaccination services is high: in a 2020 survey, 99.4% of patients stated that they would recommend the flu vaccination service to friends and family.

15. This supports the ambition that pharmacies become the home of NHS vaccinations in the mid-to-long term future. Pharmacies could take on more adult vaccinations for diseases such as shingles and pneumococcal. This would be a cost-effective, efficient and accessible service for patients, and it would free up other parts of the NHS, particularly GP practices, to focus their efforts on other priorities.

16. Pharmacies also want to do more to support women's health, prevention, public health, patients with long-term conditions, and to take pressure off general practice and other parts of the health service.

17. Patients and the public could have greater access to medicines, clinical services, and preventive care from pharmacies, empowering them with greater choice and continuity of care, giving them increased confidence in the advice and treatments they receive.

18. Community pharmacies should also have a crucial role in supporting self-care and promoting the well-being of local populations. With more pharmacists becoming independent prescribers (IPs) and newly qualified pharmacists registering as IPs from 2026, a considerable proportion of patients with self-limiting conditions should in future be able to consider community pharmacy their primary point of contact for treatment and advice, with no need for GP involvement, but with key clinical records shared with the patient's general practice.

19. This is the future we want to work towards, and we have commissioned The King's Fund and Nuffield Trust to develop a vision for the future of Community Pharmacy which will be published shortly. We agree with them that community pharmacy will experience a significant transformation over the next decade; assuming a central role in providing integrated, responsive, and patient-centred health and care services within the community.

20. But this future is by no means guaranteed. Pharmacies are facing unsustainable operational and financial pressures as since 2016, the funding received by community pharmacies has

declined by 30% in real terms. This funding squeeze has been accompanied by inflationary pressures and workforce shortages which have also driven up costs. This has pushed pharmacies to withdraw some services, reduce their opening hours, and in some cases, close permanently.

21. For many pharmacies, the future looks bleak. If Government wish to realise the more positive future that pharmacies want, and which patients and the wider NHS need, they must fundamentally review the Community Pharmacy Contractual Framework (CPCF) with alignment of care pathways and incentives within the wider primary care system.

22. The £645 million of funding for the sector – pushed for by us – and included in the recent Delivery Plan for Recovering Access to Primary Care in May 2023 is welcome, but not enough. Pharmacies need to be put on a long-term sustainable funding platform, urgently. Government must back the sector with appropriate funding so that community pharmacies have the confidence to invest.

23. In summary, we believe community pharmacy could continue to grow its role in clinical care delivered in every neighbourhood and reaching all parts of the population, reducing pressure on GPs and other frontline NHS services. But in order to do so there needs to be a stable, long-term sustainable funding commitment which will enable pharmacy owners to invest for the future.

24. The table below summaries potential service development options that pharmacies could offer.

Supporting self-care and urgent care - reducing demand on GPs and urgent care ▪ A 'walk-in patient' option for the Community Pharmacist Consultation Service (CPCS) ▪ Enhance the CPCS by provision of some medicines using Patient Group Directions (PGD) or independent prescribing (including appropriate antimicrobial stewardship) ▪ A nationally commissioned Emergency Hormonal Contraception (EHC) service ▪ Pilot the management of minor injuries (building on proof-of-concept work already undertaken)
Promoting health and wellbeing (prevention) - reducing future healthcare demand ▪ A nationally commissioned, open access smoking/nicotine (vapes) cessation service ▪ Health checks commissioned for target groups of patients and the public, using point of care testing (e.g. blood lipids measurement) with follow-up and a personalised wellbeing plan ▪ Weight management services, including targeted support for people with LTCs ▪ An atrial fibrillation case-finding service to complement the community pharmacy Hypertension Case-finding Service and the work of Primary Care Networks on CVD ▪ A COPD case-finding service ▪ Additional vaccinations beyond adult flu and COVID-19, e.g. travel vaccines, shingles, pneumococcal, childhood vaccinations and a children's flu vaccination mop-up service
Long Term Condition (LTC) support and management - building primary care capacity ▪ A nationally commissioned Inhaler technique service ▪ Commissioning Community Pharmacy England's Care Plan Service proposal

- An annual dose form/device check, synchronisation of prescriptions and adherence review for all patients using medicines for the management of LTCs
- Structured Medication Reviews, in collaboration with Primary Care Networks
- Menopause advice service, including prescribing of HRT
- A Hypertension management service (using independent prescribing) as a forerunner for other LTC management by pharmacist independent prescribers
- Pilot provision of annual asthma reviews (building on proof-of-concept work already undertaken in Leicester)

Improving patient safety and cost effectiveness - optimising use of medicines and reducing harm

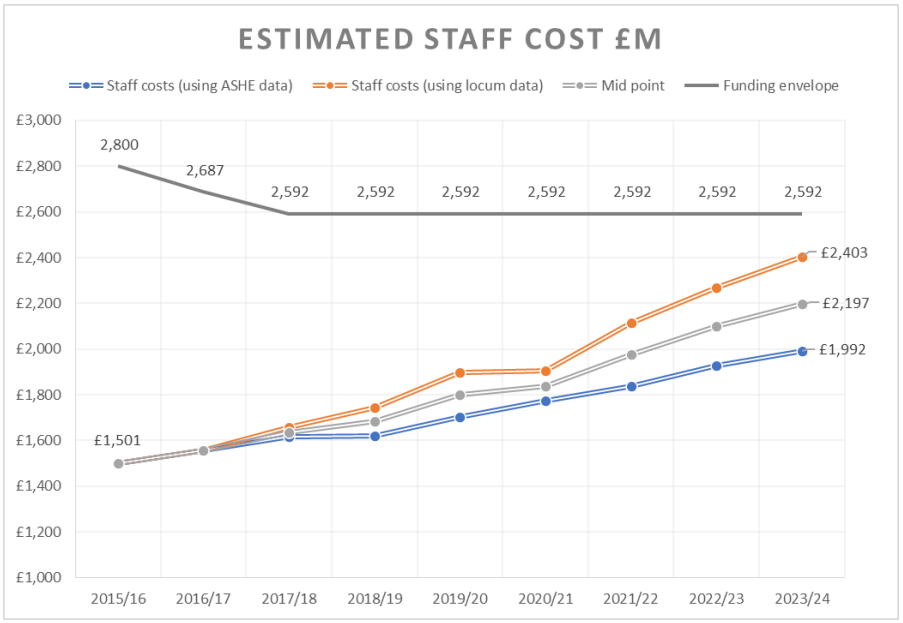
- Tackling polypharmacy and identifying potential gaps in prescribing
- Querying prescribing of medicines of low clinical value and specific medicines
- Enhanced safety interventions during dispensing (building on work within the Pharmacy Quality Scheme)
- Supporting the use of pharmacogenomics and personalised medicine to optimise the use of medicines, including specialist medicines
- Increased use of electronic Repeat Dispensing and provision of more support for LTC patients, e.g. Community Pharmacy England's Care Plan Service proposal

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

25. The growing workforce crisis is a pressing concern for the community pharmacy sector. Businesses are already struggling to recruit, and we see further huge workforce pressures on the horizon in the medium term. Some of the several reasons for this include:
    - A reduction in number of students training to be a pharmacist
    - Workforce issues related to Brexit
    - Pharmacists choosing to work elsewhere in primary care, rather than in the very pressured community pharmacy sector

26. To avoid service disruption, pharmacies are turning to locum pharmacists to fill the vacancies and to ensure that they can open. However, since the 2019 introduction of the Additional Roles Reimbursement Scheme (ARRS) more than 6,400 pharmacists and locums have been recruited into PCNs and GP surgeries. This has contributed to increased vacancies and delayed recruitment in both hospital and community and increasing locum fees, with locum costs having risen 80% in the last three years.

27. Staff costs have grown massively since 2015/16. Data from the 2010 Cost of Service Inquiry for Community Pharmacy indicated staff costs made up 53% of costs at the time. Assuming staff costs remained 53% of business costs in 2015/16, then our estimate using inflation data from the Office for National Statistics and from pharmacy businesses puts staff costs at 84% of the current available funding envelope by 2022/2023. This is shown below, and is still rising.



28. We understand and want to help relieve the pressure on our general practice colleagues, and we support career opportunities and professional fulfilment for all pharmacists, wherever they may work, but we remain seriously concerned about the further rollout of the ARRS: this must be properly planned for.

29. The recent Hewitt Report outlined that action should be taken to carefully consider the best use of the limited pharmacist workforce going forwards.

30. We broadly welcomed the long-awaited NHS Long Term Workforce Plan, released in June 2023. It outlines measures to support and develop the pharmacy workforce, and gives specific consideration to community pharmacy in recognition of what it describes as the sector's 'unique circumstances'. It notes that education and training places for pharmacists are estimated to need to grow by 31–55% to meet the demand for pharmacy services.

31. But NHS England must not repeat previous mistakes – the failure to plan properly for the impact of the ARRS on community pharmacies has been disastrous for many – and we need assurance that community pharmacy will not fall through the gaps as Integrated Care Systems take on responsibility for workforce planning.

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

32. The current level of interoperability of community pharmacy IT and IT in general practices needs improvement. In recent years, progress has been made to support interoperability, including the sharing of data on services provided in community pharmacies (e.g. flu vaccinations administered) with GP systems such that the information can be seamlessly absorbed into the patient's record at the click of a mouse. However, this currently only applies to a minority of services provided by pharmacies and data does not flow in the opposite way from general practices to pharmacies.

33. The recent Delivery Plan for Recovering Access to Primary Care included plans to address shortcomings in the interoperability of the two sectors' IT systems, with the planned application of the NHS Booking and Referral Standard (BaRS) within systems, which should in the future support the sending of electronic referrals in both directions. It is also planned to use the NHS' GP Connect service to provide community pharmacists with access to GP records, building on their existing access to the National Care Records Service. GP Connect will be developed to support more data being sent from pharmacies to general practices in a manner which will allow the receiving IT system to automatically consume the data into the patient's record.

34. There is even greater room for improvement when it comes to the interoperability of community pharmacy and hospital IT systems. Currently, only one of community pharmacy's clinical IT systems has interoperability with some hospital IT systems. That functionality is not universally available, as not all hospitals or their system suppliers have been able to support the development of IT interfaces with the community pharmacy system. The wide range and variability in the IT systems used by hospitals presents a challenge to the development of interoperable systems between the two parts of the NHS.

35. To illustrate the impact this lack of interoperability has on pharmacies and their patients, the NHS Discharge Medicines Service (DMS) became a new Essential service within the CPCF in 2021. It is designed to provide support with their medicines regimen to people who have recently been discharged from hospital. It has been proven to reduce the number of problems a patient may have with their medicines after leaving hospital and thereby reduces the likelihood of re-admission.

36. The proven benefits of the service led NHS England to fund the Academic Health Science Networks to support all hospital trusts with the implementation of referrals to community pharmacy. This included support and seed funding for the necessary IT, but despite that, the number of Trusts able to amend their IT systems to send electronic referrals to community pharmacies is low and some use NHSmail instead. Where such an approach is used to send referrals, it creates barriers to the hospital team in making them. It is not a seamless process within their IT system. For this and other reasons, the current number of referrals to the DMS is suboptimal, with a consequent negative impact on patients and the NHS.

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

37. Community pharmacies are already using innovation and enterprise to deliver pharmacy services including the use of hub and spoke dispensing by some of the larger pharmacy businesses and pharmacies providing national services from remote hubs. This includes the use of automated dispensing systems and in some cases the use of artificial intelligence (machine learning) to assist the dispensing process and seek to ensure that pharmacists spend their time making valuable clinical interventions in the dispensing process. Broadly these innovations are activity saving – and give pharmacists more time to deliver clinical services – but they are not cost saving. The investment required can increase costs. Some community pharmacies may also use smaller automatic dispensers for a similar purpose.

38. Community pharmacies provide patient services remotely, including the delivery of dispensed prescriptions and the remote provision of other clinical services virtually.For example, the New Medicine Service provides extra help and advice about a long-term medicine that has been prescribed to the patient for the first time.

39. Community Pharmacy England supports:
    - the provision of pharmacy services remotely, where this can be carried out safely and within the conditions described in the service specification.
    - the innovative delivery of pharmacy services, using new technology, for the benefit of patients and the public, to provide patients with a choice of how to access pharmacy services and to improve efficiency.
    - the drafting of service specifications to make clear that where the pharmacy services can be provided safely by remote means, this is explicit.
    - regulation of the sector that is predictable and coherent, so that it meets the objectives of the relevant legislation for the provision of pharmacy services and the use of, for example, the remote provision of services. This ensures appropriate stability and long-term investment, with confidence of a reasonable return (where there is adequate funding), subject to the normal risks inherent in markets.

40. Genomics and personalised medicine will have a major impact on patients, the NHS and healthcare professionals over the next decade. Community pharmacists are well placed to perform key roles within pharmacogenomics by supporting the application of the technology in primary care, maximising the benefits of precision medicine for patients and the NHS.

41. Similarly, developments in diagnostic technology, including point of care testing devices and the use of wearable technology present opportunities for community pharmacies to support patients and the public to monitor and optimise the management of long-term conditions. They will also be used to identify undiagnosed conditions or to support the minimisation of risk factors for long-term conditions.

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

42. Community pharmacies are funded according to a contractual framework agreed by Community Pharmacy England, the NHS and Government. This framework accounts for around 90% of pharmacies' income. The remaining 10% comes from locally commissioned services – such as from local authority public health teams – and from retail income.

43. In 2019, a five-year deal was agreed for pharmacies following three previous years of cuts. The deal introduced a range of new national services with the funding for these national services coming from the contractual framework, which is described as 'flat' – at £2.592bn each year – until the end of March 2024. This means real terms funding for pharmacies is reducing year on year, as inflationary increases are not being taken into account.

44. At the time the deal was agreed, the Government also committed to annual reviews of the arrangements – which we believed would allow us to seek inflationary and other uplifts

which did not materialise – and to introducing some measures that would help pharmacies to free up some capacity, but these are also yet to materialise.

45. Pharmacies are seeing their costs increase significantly as inflation and the cost of living remain high, but unlike other businesses, they are unable to pass on these cost increases to their customers.

46. Workforce pressures have been significant and pharmacies cannot afford to meet the associated wage increases.

47. We estimate that pharmacies will have already made efficiencies of between 69% and 115% from the period 2015/16 until 2023/2024.

48. Our analysis of costs shows that the sector was underfunded by at least 13.7% in Years 1 and 2 of the five-year CPCF.

49. Pharmacies are having a greater financial squeeze applied to them than other NHS services. While pharmacy funding has remained flat at a reduced level since 2015/16, the NHS as a whole has benefited from an annual funding growth rate of 3.4%. It is not clear to us why pharmacies are being asked to make ever greater efficiencies than the rest of the health service.

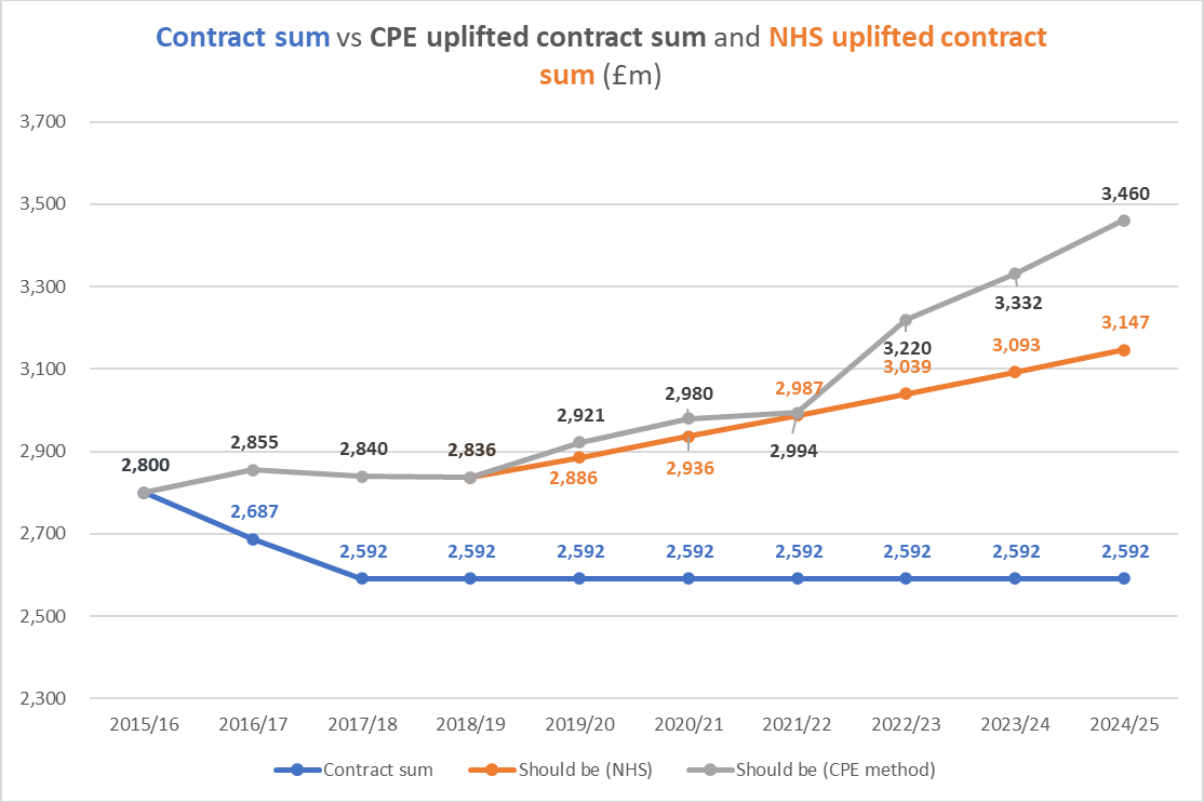
50. Many pharmacy businesses are having to take steps to respond to these pressures, and business owners are reporting failing to cover the costs of their capital or replace worn-out assets; taking short-term measures such as reducing service levels to patients; charging for services such as medicines deliveries; and increasing mergers and branch closures in the larger chains.

51. Our recent Pharmacy Pressures Survey highlighted the worsening situation for community pharmacies as rising costs and significantly increased workload put businesses at greater risk of collapse:

    - The majority (96%) of pharmacy owners are facing significantly higher costs than last year – up from 80% in the 2022 pressures survey.
    - Many are operating understaffed due to both insufficient funding (48%) and staff unavailability (34%).
    - 78% of pharmacy owners are extremely concerned about their business finances with 41% now extremely worried about their ability to help patients.

52. Almost all pharmacy team members (98%) and pharmacy owners (97%) reported that patients were being negatively affected by the pressures on their pharmacy. This reflects the extreme levels of stress that pharmacy teams and businesses are currently experiencing. Urgent funding is needed to help address some of the pressures and to protect patient services and access to medicines.

53. There are many ways to calculate how much funding community pharmacies should have – all of these are estimates. One way of doing so is to use a national inflation metric such as the GDP deflator, which we used to produce the following graph:



54. This shows that if the community pharmacy funding envelope grew in line with the NHS' overall annual funding growth of 3.4%, it would reach £3,147m in 2024/25. Alternatively, if the envelope grew in line with the national GDP deflator rate, it would reach £3,460m by 2024/25.

55. The only way to truly assess the cost of delivering the service is through a full Cost of Service Inquiry. We hope this will be properly evaluated as part of the Economic Review that NHS England is currently commissioning.

56. In future, as well as a full review of the CPCF, we would like to see a fairer benefit-sharing approach taken to commissioning of pharmacy services – pharmacies should be paid according to the value they deliver, and where pharmacies make billions pounds worth of savings for the NHS in effective medicines purchasing some of this should be shared with the sector rather than clawed back from struggling businesses.

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

57. Community pharmacies in England dispense over 1 billion prescription items every year, with patients relying on access to these medicines for their health and wellbeing, and very often even to save their lives. But we are increasingly seeing disruption in the supply of medicines with problems both accessing them and procuring them cost effectively, and this is a cause for great concern.

58. Community pharmacy owners in England are under immense pressures and they have recently (July 2023) rated medicines supply instability as being the most severe pressure

facing their businesses. The instability puts operational pressures on pharmacies, financial pressures on businesses, and for patients it means worrying delays.

59. Our 2023 Pharmacy Pressures Survey found that:
    - 92% of pharmacy teams are dealing with medicine supply issues daily, an increase from 67% in the 2022 pressures survey.
    - Almost all pharmacy owners (97%) reported significant increases in wholesaler and medicine supply issues.
    - And 71% of pharmacy owners reported significant increases in delays in prescriptions being issued.

60. Medicines shortages and supply issues can be caused by a variety of factors from manufacturing, regulatory problems or distribution issues (including delays in delivery and transit times) to drug recalls, stockpiling or simply increased demand. In the current economic climate, the very low drug reimbursement prices in the UK – testament to the hard work of pharmacies shopping around for the best prices – may not be helping the situation either.

61. We believe wider medicines market problems are being caused by a combination of factors such as Brexit, COVID-19, war and inflationary pressures. It also seems to be the case that the very low prices of medicines (as driven by effective procurement by pharmacies) in the UK leave our market more susceptible to global market shocks.

62. We believe that there is something fundamentally wrong with the medicines supply chain. The Government needs to get a better handle on the situation to protect both patients and pharmacies. But, for now, exhausted pharmacy teams are caught in the middle as they spend longer hunting down limited stock and paying inflated costs without knowing if they will be reimbursed appropriately.

63. Community Pharmacy England would like to see the following steps being taken to help resolve the issues faced by community pharmacies and their patients.
    - **Reform of Serious Shortage Protocols (SSPs):** We want to see greater flexibility for pharmacists to carry out simple changes, such as quantity, strength and formulation changes, without the need for prescriber authorisation or an SSP. Pharmacists are eminently qualified to do this.
    - **Generic Substitution:** Pharmacists should be allowed to supply any equivalent generic medicine against a prescription requesting a brand which may be in short supply. Generic substitution is commonplace in many countries around Europe, and allows pharmacists to help manage supply without having to trouble prescribers.
    - **Overhaul the concession pricing system**: Pharmacy businesses cannot subsidise the NHS medicines bill and while the concession pricing system is designed to help prevent this, the system is no longer coping with the current price volatility in the market. While some reforms have been made to the system, further improvements are needed.
    - **Undertake a strategic review of medicine supply and pricing:** Community pharmacies have helped to drive down medicines prices over many years and competitive generic prices in the UK now leave us more vulnerable to the impact of global market shocks. But despite the billions of pounds in savings that pharmacy procurement brings, the margin that pharmacies are allowed to earn on medicines purchases has been capped at the same level for many years: this is yet another pressure at a time when pharmacy businesses are fighting for survival. We would like a more balanced benefit-sharing approach to be taken and to see a shift in focus with DHSC focused on how to improve

the functioning of the supply chain rather than solely on the drive to depress prices and margins which has contributed to the difficult situation now being experienced by pharmacies and their patients.

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

64. The Government's pledge of a £645 million investment in community pharmacy over the next two years to support a pharmacy Common Conditions Service, and expand the NHS Pharmacy Contraception Service and NHS Hypertension Case-Finding Service is the most significant investment in community pharmacy in well over a decade. But it does not address the underlying funding and capacity issues within the community pharmacy sector.

65. We are currently negotiating on how the funding is delivered to ensure that community pharmacies have the core capacity to meet patient needs and deliver completed episodes of care. We remain focused on the huge pressures facing pharmacy businesses.

66. We hope negotiations will conclude soon and will share further information with the Committee at that point.

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

67. It is the responsibility of the Secretary of State for Health and Social Care to ensure there is good access to pharmaceutical services across the country.

68. It is up to each area's local health and wellbeing board (HWB) to determine what their local pharmaceutical services provision looks like through a pharmaceutical needs assessment, which they must publish every three years. Integrated Care Boards with powers delegated by NHSE England decide whether applications for new pharmacies should be granted. We believe that this framework is generally working well, and this was the finding of the Department of Health and Social Care's post-implementation review of the legislation in 2018. There is one exception to this which is discussed later. The system has been in place for a number of years which has enabled new pharmacies to establish to meet patient needs.

69. Pharmacies may sometimes be grouped together on the High Street, but this may be so that they can be close to GP surgeries or to increase patient and public footfall for prescriptions etc. The capacity of one pharmacy may also not be sufficient for the area served and supported. In some cases, pharmacies have been consolidating to reduce costs.

70. There may be a small number of pharmacy clusters which are due partly to previous Government policy or the way the sector was managed 10 or more years ago. However, each pharmacy serves a community, the capacity of each may be important to the area, some may serve very different communities, such as nursing homes, and each is a separate business. There is no longer any funding for an Establishment fee which supported the

infrastructure and hub and spoke dispensing that such pharmacies could use has been promised as part of the 5-year deal agreed 4 years ago.

71. There are currently approximately 10,800 community pharmacies in England. This is down from around 11,200 in 2021 and over 11,700 in 2017. Where pharmacies close this can have a disastrous impact on local communities as well as putting extreme pressures on neighbouring pharmacies and GP practices.

72. We are extremely concerned about the ongoing trend and risk of pharmacy closures which we and others have already warned could overwhelm other pharmacies and put the supply of medicines to patients at critical risk.

73. The exception to the otherwise broadly satisfactory process for deciding where new pharmacies will be located, relates to what has been termed 'local' Distance Selling Premises (DSP) pharmacies.

74. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 - which deal with the application process for new pharmacies - make provision for DSP pharmacies with national availability of Essential services. The intention of the regulations is that such pharmacies provide pharmacy services remotely to patients, at least in the majority of cases, including for the provision of Advanced services.

75. The establishment of 'local' DSP pharmacies primarily providing pharmacy services in the immediate area, similar to pharmacies established in accordance with the normal application process for High Street pharmacies that reference patient needs, circumvents and undermines these regulations. 'Local' DSP pharmacies were not envisaged or intended by the application process or these regulations and furthermore, the number which can be established is without limit because the application process is without reference to patient needs in an area. (They were intended to provide services nationally or at least an area much wider than the locality).

76. Community Pharmacy England has asked the Department of Health and Social Care to address this issue and suggested ways in which this might be done, to ensure the policy objectives of these regulations are met. These objectives include:

    - to ensure a proportionate regulatory regime which encourages the supply of NHS pharmacy services without excessive provision in areas already meeting demand;
    - to ensure benefits of the new entry system outweigh its costs; and
    - to align provision more transparently with local needs.

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

77. Community pharmacies operate on a contractor model similar to other primary care providers such as general practice. The commissioning landscape for community pharmacy is complex and involves NHS England, NHS Integrated Care Boards (ICB) and Local Authorities. Community pharmacies are contracted and commissioned in England under the national Community Pharmacy Contractual Framework (CPCF).

78. The CPCF is negotiated nationally between NHS England, the Department of Health and Social Care and Community Pharmacy England. In the past, this agreement was typically done on an annual basis, however, there has been a recent move to a multi-year agreement to help fulfil the ambitions of the NHS Long Term Plan, which comes to an end in March 2024.

79. NHS England has delegated responsibility for commissioning community pharmacy services in local areas using the CPCF to the 42 ICBs. Usually, this means local NHS pharmacy contracting teams monitoring contracts with their local pharmacy premises.

80. The CPCF will continue to be negotiated at a national level by Community Pharmacy England, the Department for Health and Social Care and NHS England.

81. We welcome this continued commitment to national contractual arrangements across the primary care contractor professions, which should ensure patients across the country can continue to access the medicines and services they need, while also allowing the many small, medium and large pharmacy businesses who operate across different regions, to do so with relative ease.

82. The recent changes in the local NHS, particularly the dissolution of clinical commissioning groups, should provide the opportunity for better use of local commissioning of primary care services by the NHS and local government, without the issues that have been seen when much of this is driven by organisations whose governance is led by the representatives of one primary care profession.

83. The delegation of decision making and budgets by the ICB to place level (generally the local authority area) could allow better alignment of local NHS commissioning and need, but robust governance systems will need to be put in place to ensure equitable decisions are made on commissioning services.

84. 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. Yet community pharmacy needs to be considered as a key and critical element of the primary care system. There needs to be better alignment of the community pharmacy and general practice contracts – so that they are not competing for service fees – for instance in the delivery of flu or COVID-19 vaccinations. While GPs and community pharmacies are both private businesses offering publicly-funded NHS services, the GP contract includes payments for premises, IT systems, workforce development and training which are not adequately funded by the community pharmacy contractual framework.

85. 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 providing a share of the benefits of good performance by contractors in the funding they receive.

86. While the commitment to national contractual arrangements can provide protection of agreed funding at a national level, it is possible for funding distribution to be distorted at a local level, as is seen now in some cases, such as in relation to agreed medicines purchase margin (e.g. the application of branded generic purchasing policies by some NHS organisations). Checks and balances must be in place to prevent this.

July 2023