Written Evidence Submitted by Company Chemists' Association

(CLL0020)

About the Company Chemists' Association (CCA)

Established in 1898, the CCA is the trade association for large pharmacy operators in England, Scotland and Wales. The CCA membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 6,000 pharmacies, which represents nearly half the market. CCA members deliver a broad range of healthcare and wellbeing services, from a variety of locations and settings, as well as dispensing almost 500 million NHS prescription items every year. The CCA represents the interests of its members and brings together their unique skills, knowledge and scale for the benefit of community pharmacy, the NHS, patients and the public.

Executive summary

- Secretary of State for Health and Social Care, Matt Hancock, refers to community pharmacy as the 'front door' to the NHS. Yet during the height of the coronavirus pandemic, there was an absence of a coherent government strategy that supported pharmacy teams in the same way as the rest of the NHS or even other key workers. This resulted in our members making decisions about social distancing in pharmacy stores and use of PPE ahead of government advice because it was not available when needed to keep the public safe.

- This response highlights concerns around communications from government bodies, concerns around the timeliness of decision making and concerns about the lack of recognition for the community pharmacy sector as either key workers or deliverers of the nation's medicines and NHS services. As a result of these gaps, community pharmacy contractors needed to make key decisions, rapidly, and without the support of government to ensure continued supply of medicines and healthcare services to the public. This response is largely focused on the experience in England but does also reference where decisions were reached differently in Scotland and Wales.

- **Lessons learned –** we call on the government to learn from the lessons of the pandemic and the need for preparedness. We are concerned that execution of lessons learned is not happening when it comes to the pharmacy sector and planning for track and trace and the delivery of the Covid-19 vaccine. We ask that community pharmacy teams are considered as keyworkers and integral to the vital supply of medicines to the public and consulted and factored into policies at the earliest possibility. This will help to alleviate any unintended negative consequences on the provision of care to the public and support efficient delivery of medicines and healthcare advice. On a macro level, the pandemic has demonstrated a need for resilience across the healthcare system. Resilience could be enabled by better technology and digital integration, a reduction in bureaucracy and fairer funding for the supply of medicines as well as for delivering healthcare services.

Response

The CCA welcomes the opportunity to submit evidence to this inquiry into lessons to be learned from the response to the coronavirus pandemic so far. As the 'front door' to the NHS, the community pharmacy

sector was the frontline to tackling Covid-19. Pharmacists and pharmacy teams rose to the challenge of unprecedented demand to support their local communities through a once in a lifetime global health crisis. Community pharmacy remained open without appointment which increased pressure and demand for prescriptions, advice and support. A record 93 million prescribed medicines were dispensed in March 2020 immediately before lockdown, the most since current records began in 2014. Understandably, the focus of community pharmacies initially shifted to medicines supply and core services. Some pharmacies may be irreversibly damaged by the financial impact of this because they were not receiving funding for additional services, risking their longevity and crucial provision of healthcare within communities.

The community pharmacy sector faced an unparalleled period where it was often the only health service provider which remained 'open' to the public as many general practice surgeries closed or provided remote digital only consultations. Despite this, community pharmacy showed rapid and agile decision-making to ensure patients could access their medicines.

The pivotal role of community pharmacy in supporting the public within communities did not have a government strategy to underpin it. As the CCA, the only policy we initially had to refer to for advice was a document developed by government in 2013 and last updated in 2017. It was based on the 2009 Swine Flu outbreak and relied on the next pandemic being a pandemic flu.

As this was not a flu pandemic the existing policy did not support the necessary decision making required on the ground. Governmental bodies delayed in offering substantive support and businesses were forced to make autonomous decisions to best support the health of the nation and the wellbeing of pharmacy teams. Furthermore, official guidance was frequently provided several weeks after it was required and on some occasions was slightly different to what businesses had decided to do which created confusion for pharmacy teams and the public. The CCA proposes that member businesses should be supported in making their own decisions or official guidance should be prompt.

The CCA has decided to submit this evidence to the joint inquiry to help the UK government understand the sector's experience of this pandemic and to drive learnings and improvements for future waves of this coronavirus, or indeed any novel coronavirus or threat to the safe and continuous supply of healthcare to the public. For ease of reference, we have themed our feedback around communications, decision making, recognition, resilience and recovery and lessons learned. We would be happy to provide further evidence to support these examples, or any other areas the inquiry may be interested in, if requested to do so.

Communications

From the early onset of the pandemic, intelligence from European countries, including Italy and Spain, was not assessed and shared with the public or key industry leaders. The health sector, including community pharmacy, was not prepared for the escalating threat that the Covid-19 virus posed. In a stakeholder communication on 10 February which confirms that '1,114 people have been tested, of which 1,106 were confirmed negative and eight were positive.' It notes that '*in accordance with Regulation 3, the Secretary of State has declared that the incidence or transmission of novel Coronavirus constitutes a serious and imminent threat to public health, and the measures outlined in these regulations are considered as an effective means of delaying or preventing further transmission of the virus.'* It goes on to state that, '…*the NHS is well prepared to deal with coronavirus*.' At this time, the CCA membership organisations did not consider themselves to be well prepared and set up a 'pandemic planning group' to share and discuss the intelligence that we were gathering. Some of the issues encountered in the initial weeks of the Covid-19 outbreak are summarised below.

- In the initial outbreaks, GP surgeries were included in a 'deep clean' public health response but community pharmacy were missed out in circumstances where the patient went from the surgery

to the community pharmacy. Surgeries and community pharmacies also closed ‘all day’ which was disruptive for local populations.

- Messaging from Public Health England (PHE) and Department of Health and Social Care (DHSC) was often unclear on key topics such as home isolation and using travel as a discriminator to rule Covid-19 in or out.
- NHS England and Improvement (NHSE&I) did not initially ‘take the lead’ with informing community pharmacy about key changes in the strategy for managing the virus. Other sectors (optics and dentistry) were in a similar isolated position and were supported by weekly calls led by the Royal College of General Practitioners (RCGP).
- RCGP call with medics, pharmacy, dental and optical helpful but disbanded due to overlaps with NHSE&I call.
- During the same time period, the sector’s negotiating body, the Pharmaceutical Services Negotiating Committee (PSNC), held a fortnightly call which brought together NHSE&I, DHSC, trade associations, member organisation representatives, regulators and devolved nation representatives to share concerns and intelligence.
- The PSNC call was also disbanded because of overlaps with NHSE&I’s call.
- NHSE&I’s call had originally covered a wide proportion of the sector and was split to pharmacy bodies only before reconstituting with more frequent meetings with the Chief Executives from the five main representative bodies in Pharmacy (AIM, NPA, CCA, RPS and PSNC). This was an engagement method which existed prior to Covid-19 and many across the sector expressed their concern that they were no longer able to access intelligence and share solutions across organisations and nations in the same way as had been possible with the RCGP and PSNC calls.
- It was not always clear what guidance to the sector was 'official.’ For example, an update was published as ‘guidance’ which was answers to questions from a Primary Care briefing call and this was later clarified.
- Guidance from PHE on issues such as PPE was sometimes unclear, or sometimes contradicted by guidance from other bodies including the pharmacy regulator, General Pharmaceutical Council (GPhC) and the professional body, RPS. It is suggested that advice from PHE was driven by the availability of PPE rather than protecting the safety of pharmacy teams and the public.
- CCA developed its own ‘white label’ guidance to bring consistency in interpretation of the various pieces of guidance from PHE and NHSE&I and shared this with the community pharmacy sector, including locum pharmacists.
- The sector was not engaged on the government’s coronavirus action plan and had concerns but few mechanisms for channelling these concerns. For example, the ‘contain’ stage of the plan continued into March, which was longer than it should have done. Official guidance was that travel should still be used as a discriminator (i.e. identifying patients who had recently travelled to a known affected area) when treating patients with symptoms of coughs and illnesses that could potentially be caused by Covid-19. At this point it was known that Covid-19 was circulating in the community. For community pharmacy, which acts as a health service for people with coughs and flu-like symptoms, this was a major concern. We were still receiving walk-in patients and referrals from the NHS111 service. Yet, PHE and NHSE&I seemed unwilling to change the advice until the government had shifted the UK into the ‘delay’ stage.
- It was difficult to seek clarity on important topics as the sector was advised to raise concerns with NHSE&I through a pro-forma which was online. This meant that important questions raised by members did not get a response for 1 - 2 weeks.
- Communication about expectations around opening hours for the Easter Bank holidays did not give contractors sufficient notice to prepare.

Often the information communicated by government and NHS bodies was through evening webinars or emails at short notice. This means that employers needed to act quickly to communicate often substantial

updates to all contractors and pharmacy teams so ways of working could be amended. To better support the sector, community pharmacy organisations need to be trusted with information in advance so they can prepare for changes and support their teams and the public.

The communication from Welsh Government and Scottish Government on key issues was different and often at pace in comparison to England. Some key points have been included below and further information can be provided, if required.

Wales and Scotland

- In Wales, before lock-down, the Welsh Government relaxed a range of elements of the terms of service to reduce bureaucracy and increase agility. In England it was much later.
- In Wales, a number of activities were either cancelled or suspended but the funding still flowed to the pharmacy.
- In Scotland the creation of Covid hubs which handled deliveries of medicines to patients worked well and relieved pressure around increased repeat prescriptions (in contrast to the English system which had lengthy delays).
- The Welsh Government delivery solution was slow and unwieldy for contractors and started in May – June.
- Minor Ailments Service (MAS) extended to whole population of Scotland. By 9th April registrations were increasing by more than 200 per day.
- On 7 April Scottish Government announced that an additional £5.58m would be available to contractors to cover additional infrastructure and staffing incurred during March (this is still being negotiated in England).

Decision making

The community pharmacy sector found that decision making to enable our sector to better serve the public during this pandemic often faced a bottle neck around a few key people in NHSE&I and DHSC. Decision making was also not streamlined regarding how decisions were reached between these organisations.

The community pharmacy sector worked together to produce a single issues list which compiled the key concerns that required a decision and updated this for NHSE&I and DHSC colleagues on a weekly basis. However, decision making and engagement with the issues did not appear to be methodical or agile (i.e. seemingly no differentiation between decisions in terms of their importance and risk. Therefore, the same thorough process was followed for many decisions even if they were low-risk and/or uncritical.). This level of responsiveness meant that businesses needed to make individual decisions about social distancing (e.g. only allowing one or two people in the premises at any one time), opening hours and disbanding core services. This impacted consistency in approach across the sector but was necessary to ensure the continued safe supply of medicines to the public. However, official guidance was frequently provided a few weeks after it was required and on some occasions was slightly different from what businesses had decided to do and this created confusion for pharmacy teams and the public. CCA member businesses should be supported in making their own decisions or official guidance should be prompt. Furthermore, businesses were concerned by the punitive action they may have faced for taking necessary and emergency measures (e.g. NHS breach notices for not fulfilling the contractual terms of service and admonishing letters from the pharmacy regulator).

Recognition

The CCA, alongside the Association of Independent Multiples (AIM), the National Pharmacy Association (NPA) and the Royal Pharmaceutical Society (RPS) wrote to Matt Hancock on 24 March 2020 to ask two

urgent questions. The first was around funding for the additional expenses that pharmacy contractors had to cover for items including PPE, making pharmacies Covid-secure with Perspex screens and cleaning and additional staffing costs to cover sick leave. We also noted that contractors' cash flow difficulties were being impacted by rising prices of medicines. To date, the community pharmacy sector in England has only received advance funding to help mitigate cashflow issues due to Covid-19 as well as payment of £300 per contractor for the cost of Perspex screens. Similar negotiations also took place in Scotland and contractors received a settlement many months ago. We suggest that the levels of engagement around decision making between senior leaders in the NHS, Department of Health and Social Care and the Treasury are insufficiently robust to deal with a crisis in healthcare such as the one we have faced. Moreover, the role that the sector stepped up to meant that, in dealing with high demand for medicines and advice, community pharmacies were unable to deliver healthcare services which are attached to contractual funding. Over-the-counter sales for non-prescription items and other over-the-counter sales were also greatly reduced which had a significant impact as many contractors use these sales to support their businesses financially as dispensing is a low margin activity or in some cases a loss-making activity.

The second question we asked Matt Hancock was to publicly provide the sector with recognition. There was a double impact in the way in which pharmacy teams were overlooked during Covid-19. A lack of recognition for key worker status initially impaired our colleagues' abilities to shop for their families because they were turned away from priority hours at supermarkets, they were unable to continue to send their children to school and there was consternation about whether pharmacy professionals would be eligible for 'death-in-service' payments. Additionally, colleagues' morale was deeply impacted by not being cited by senior politicians or visibly included in the 'clap for the NHS.' Each of these issues were addressed, to some degree once the sector raised them. However, there remains concerns about the timeline of events and what this means for future decisions among senior leaders who purportedly view community pharmacy as the 'front door' to the NHS.

Community pharmacy is the hub for healthcare services within communities and uniquely has increased access in areas of high deprivation. Often pharmacies are open longer hours and at weekends. Services delivered through community pharmacy, naturally target those for whom the need is greatest, giving the biggest impact to the NHS. Therefore, recognition that community pharmacy was at the front line of the coronavirus pandemic, providing vital medicines and healthcare advice to a worried and anxious public, will benefit those most in need of healthcare and ensure that preventative interventions, medicines, advice and support continue to be provided to areas where health inequalities are prevalent.

Resilience and recovery

As part of the recovery for Covid-19, it is important that the sector continues to communicate and engage with the rest of primary care to promote mutual resilience. There are several pharmacy- specific asks which we have shared with NHSE&I including allowing community pharmacy to have greater responsibility for managing repeat medication. Ongoing supply problems, exacerbated by Covid-19, cause increased workload for general practice and community pharmacy teams alike. Transferring responsibility for the 'practical management' of medication supply will reduce this, with responsibility for the treatment remaining with the prescriber. Examples include a greater use of electronic Repeat Dispensing (eRD) and the ability for community pharmacists to manage prescribing periods.

To support the wider NHS, community pharmacies need assistance to develop or improve links between pharmacy teams and other professionals. Existing services, such as the Community Pharmacist Consultation Service (CPCS) have already shown that referrals into community pharmacy can be dealt with, at high volume, with high patient satisfaction. These established referral pathways can be broadened to include receiving more referrals from NHS111 and from general practice and accident and emergency (where appropriate). This will help mitigate issues with reduced capacity in the NHS and the upcoming period of unknown levels of winter pressures, and with the second wave of Covid-19. Other long-term solutions to addressing pressure on the healthcare system include investing in automation and technology, such as enhanced digital interoperability across primary and secondary care. Another way to reduce the burden on healthcare providers is by reducing the level of bureaucracy within systems and

processes. Like the Royal College of General Practice (RCGP), we believe that replacing outdated regulations that stifle bureaucracy will enable health professionals to focus on patient care. However overall, giving community pharmacists more autonomy will deliver better patient care, more flexible delivery of services and the ability to react to local needs in any crisis situation and any future spikes in the current pandemic.

Lessons learned

As highlighted in this response, it is important for the government to include working with the community pharmacy sector and apply the lessons learned to test and trace and to planning for Covid-19 vaccine delivery. Furthermore, as the UK addresses the need to manage a 'second wave' of Covid-19 which may significantly impact the ability of the health sector to deliver care to patients, then it is vital that the government makes timely decisions and gives the sector autonomy to make decisions where appropriate and in patients' interests.

(November 2020)