EIC0935

Written evidence submitted by Phoenix Medical Supplies Ltd

Phoenix Medical Supplies Ltd.
Phoenix Medical Supplies (PMS) includes Phoenix Healthcare Distribution (a pharmaceutical wholesaler), Rowlands Pharmacy (a chain of approx. 500 community pharmacies) and NUMARK (an independent pharmacy support group with over 4000 independent community pharmacy members) as well as several other pharmaceutical subsidiaries.

To what extent do Government measures protect viable jobs in the future and reduce the risk of long-term unemployment?
At the start of the pandemic, the Secretary of State for Health stated that "we'll give the NHS whatever it needs and we'll do whatever it takes". Community pharmacy contractors were told that this statement included us. As a result community pharmacy contractors, in good faith, spent their own money to ensure the pharmacy service did not collapse and that patients received their medicines and advice. This included, at the outset, having to purchase our own PPE to protect our colleagues. Community pharmacy contractors are independent businesses just like GPs and dentists. However, unlike GPs and dentists additional funding to cover the costs incurred during the pandemic has not, to date, been agreed.

It is true that an advance of funding (£370m) was made available but it was made clear that this was a loan to be repaid not a funding boost. A token gesture of £300/ pharmacy was also paid but this represents a miniscule amount of the costs incurred. While Business Rates Relief and Individual Property Grants were welcome they did not provide anywhere near the funding required to offset that being spent by contractors (and the latter was subject to State Aid Rules too meaning large pharmacy contractors could not claim against every premise in their portfolio).

According to a recent Ernst & Young report almost 50% of pharmacies are now operating at a loss and the ongoing funding squeeze being placed on community pharmacies through the contractual framework agreement with NHSE+I and DHSC is only going to make that worse. This situation has only been exacerbated by the pandemic (and the absence of specific pandemic funding) meaning that large parts of the network are now at risk.

The result of the above is that community pharmacy contractors have been left in a perilous financial state despite being considered an essential service through the pandemic and remaining one of the few businesses remaining fully open during both lockdowns. Clearly this financial stress affects the viability of jobs in the community pharmacy network which includes highly-trained pharmacists and support staff many of whom live in the communities that they serve. The Government has a window of opportunity to invest in community pharmacy to protect those jobs. The first step would be to write off the advanced funding loan and agree how ongoing COVID costs would be reimbursed. Separate funding and support arrangements have been made over the pandemic to the hospitality, transport and arts sectors so it is questionable why Government has not yet resolved this issue for a vital frontline health service.

The UK government implemented a furlough scheme early on in the pandemic. A small number of PMS colleagues were furloughed at various times in the pandemic. This enabled us to backfill their roles while they were shielding to support colleagues remaining in pharmacies or wholesale depots.

However, as a responsible employer, we paid 100% salary to furloughed colleagues but, unlike many other businesses using the furlough scheme, as our business was operational throughout we still had to pay for those roles to be backfilled so it actually left us worse off (as we paid 100% to those

colleagues furloughed and 100% to those backfilling their roles but could only claim 80% - and then the lesser amounts as that dropped).

To what extent are Government measures value for money for the taxpayer?
The Government has a legal obligation to ensure the supply of medicines to the population. Pharmacies were the only healthcare environment remaining fully open for patients throughout the crisis and provided a valuable drop-in service for patients displaced from other healthcare environments. The community pharmacy network in the UK is, we understand, the cheapest pharmacy network in the world on a per capita basis and has consistently driven down medicines prices saving the DHSC over £10bn over the last 10 years.

If the Government does not deal with the funding challenges referenced in the previous question (reimbursement of COVID costs and ongoing funding levels) then it is likely that large parts of the network will be at risk. If pharmacies close in significant numbers then an alternative medicines supply and advice structure will need to be put in place which is likely to cost considerably more than the current network. This would represent a shocking lack of value for money for the taxpayer.

How effective is the Government support to businesses and individuals across different regions and sectors? Does the effectiveness of the Government support vary across different regions?
Central Government support for community pharmacy has been extremely poor. Decision-making can at best be described as 'glacial' in its speed. While the advance funding loan, business rates relief and property grants were welcome, the apparent inability of Government to reach agreement on payment of COVID costs incurred by community pharmacy highlights that Government support is lacking.

During the pandemic, to keep pharmacies open and safe, contractors needed to move extremely rapidly, in some cases changing guidance to pharmacy teams a couple of times per week. Government, and in particular NHSE+I, were completely unable to keep up. This added a large amount of cost into community pharmacy operations which was totally unnecessary.

Other examples include:

- NHSE&I took over 2 months to decide to commission a delivery service for patients who were shielding by which time large numbers had already made alternative arrangements. The service itself was overly complicated and the funding for it was insufficient as a result.
- Regional variations regarding Test and Trace are currently causing a huge amount of disruption for community pharmacy with many local public health teams refusing to acknowledge national guidance and 'making things up' locally. Furthermore, a not insignificant number of local public health teams refuse to accept that community pharmacies are healthcare environments and apply other retail guidance when COVID cases are identified with pharmacy staff. All of this adds complexity, time and cost to community pharmacy operations and in some cases has resulted in pharmacies closing. Pharmacies are paid on activity basis so that a closed pharmacy would not be earning money which further affects viability.
- Despite promises regarding PPE being made available to community pharmacy, for much of the early part of the pandemic PPE was not available via the NHS. Community pharmacy businesses were required to invest significant sums in PPE often with inflated costs. This forms a substantial part of the un-met COVID costs currently in negotiations with DHSC/ NHSE&I.
- To get clarity on some aspects of the furlough scheme we had to seek clarity from HMRC via social media.

What lessons can be learnt from the different approaches undertaken by the nations in the UK to combatting the coronavirus?
The Scottish Government quickly engaged the community pharmacy negotiating body and worked collaboratively on relaxing regulations and increasing funding (as well as making cash-flow loans available). Scotland also quickly set up COVID delivery hubs which were able to deliver medicines to people shielding at home using the local authority workforce.

The Welsh Government acted in a similar way to Scotland and, very early in the pandemic, "went in hard and fast" to reduce regulations, ensure funding for suspended activities continued to flow to pharmacies, remove bureaucracy and agree initial advance funding.

This contrasts with the haphazard, bumbling approach and glacial pace with which the Government responded in England. While community pharmacy was struggling to stay afloat almost every decision Westminster made (especially NHSE+I) took weeks longer than it needed to. An example of this is that it took NHSE+I until September to agree that written consent was not required from patients for pharmacy services (as an infection control measure) when this had been agreed at the start in Wales and Scotland.

It is clear that having three parties involved in agreeing changes in England (DHSC, NHSE&I and PSNC – the community pharmacy negotiator) is a significant disadvantage. However, it should be noted that DHSC was much more agile than NHSE&I.

The result is that goodwill towards the Government in England has largely run out from community pharmacy contractors. Businesses with pharmacies in Scotland and Wales are far more likely to invest there than in England as a consequence.

Overall, there has been a lack of national direction in England and a consequent inability to ensure local structures follow national guidance when it is available. This has not been seen to anywhere near the same extent in the devolved nations; Scotland in particular minimised variation in approach.

What impact will a second lockdown have on the economy? How should the Government best support the economy if intermittent lockdowns become a feature over the next year?
To retain business viability any financial support or bureaucratic easing must continue for as long as there are restrictions to normal operations in place. Each new lockdown introduces its own costs and to stay open the need for economic stimulus remains. We would welcome consideration of location-specific relief, based on the tiers system.

Additionally, new and ongoing COVID costs need to be reimbursed. To support this an agreement should be reached as soon as possible for how these will be calculated, what evidence (if any) is required and how this will be distributed.

Investment in community pharmacy would have wider economic benefits beyond sustaining employment in the sector. It would enable people to have continued access to primary care advice, support and services which are understandably restricted (GP surgeries/A&E). Poor healthcare provision has both direct (NHS demand) and indirect (inability to work and consequent Government welfare payments) consequences.

COVID, like the flu, is likely to be with us for years to come. We therefore need to reset primary care provision and recognise that community pharmacy is a critical third pillar of healthcare provision

alongside GPs which enables the best outcomes for patients at the lowest cost to taxpayers. The current system, which under-utilises community pharmacy is economically inefficient.

What changes to the economy are now permanent?

- **What difference will the discovery of a vaccine and/or treatment make?**
- **Will behavioural changes such as working from home necessitate structural changes, whether or not a vaccine is discovered?**

Prior to the pandemic many community pharmacy contractors operated a limited, private, unfunded delivery service to patients. During the peak of the pandemic a funded delivery service was made available in England. When the first lockdown ended the funding for this finished except in areas under local lockdown. This meant that patients who had been receiving a funded delivery through the pandemic arrangements now expected a delivery even though no funding was available. This caused a great degree of disruption and upset in pharmacies as patients were told that deliveries to them had been stopped. These patients frequently became aggressive to pharmacy staff and on occasion became physically violent. This represents an unintended change in population behaviour.

While the permanent impact is yet to be determined, changing public behaviours have dramatically affected footfall in previously high-trafficked areas. For example, health centres traditionally see high numbers of patients but telephone consultations by GP surgeries and new working from home practices have resulted in patient cohorts changing how they access pharmaceutical services. This, in turn, risks the viability of some premises where costs (such as rent) are calculated on previous income opportunities. It is unclear how permanent these changes are but we would urge that the Government gives careful consideration to how to work in a co-ordinated fashion with businesses local authorities and, in particular, NHS Property Services to understand and buffer this transition.

Communities and local economies/high streets that were already in decline before the pandemic are seeing an acceleration in this trend with a consequent impact on jobs.

How large a problem is corporate indebtedness? How effectively did the financial sector give assistance to businesses?

- **Is there a need for a new state sponsored investment bank? If so, what should it do?**

In England the community pharmacy sector is basically bankrupt. There have been reports from Ernst & Young, the Government's own recently-released Impact Assessment and the recent APPG report which demonstrate this.

Hundreds of pharmacy closures have occurred and more will follow. There appears no plan to rescue pharmacies from closure.

What improvements can be made to institutions to ensure that responses to crises like these are more robust in the future and policy makers have the data they need? What further analysis should the Government do and make transparent?

Community pharmacy is an essential part of the NHS and is the only part of NHS primary care to remain fully open throughout the pandemic. While we are contracted in a similar way as GPs and dentists, we, operate in a fundamentally different way. Working on an activity payment basis means any restrictions or reductions to workload undermines the health of the business in a way not seen in the wider NHS. Similarly, local restrictions and changed patient pathways mean that local service income required to supplement an insufficient national contract was significantly curtailed. Pharmacies face the very real possibility of bankruptcy if they are unable to receive sufficient income. Other NHS providers do not. This is why payment of our COVID costs incurred is so vital as well as revisiting the current under-funded pharmacy contractual framework.

The excruciatingly slow decision-making processes of Government and the NHS caused (and continue to cause) considerable disruption for community pharmacies. There appears to be a complete lack of concern about the impact these processes are having. The fact that almost 9 months after the initial lockdown was announced the funding promised to the sector has yet to materialise should be considered shameful.

In many cases contractors were forced to make unilateral decisions on key aspects of disease control because DHSC, PHE or NHSE&I could not keep up with the pace of change. This, in turn, caused patient confusion and added costs where decisions were made in good faith but later needed to be reversed. These challenges of decision making were compounded by the split (and occasionally competing) responsibilities of NHSE&I and the DHSC.

Policy makers need an understanding of how cash flow, in particular, can drive behaviour. The stress placed on business owners, compounded by an uncertain advance loan repayment term, affects business decisions including keeping premises open and colleagues on the payroll. As demonstrated during the pandemic, community pharmacy provided an essential lifeline to communities and the NHS; not to maximise profit but as part of a wider social responsibility. By understanding the cash-flow and funding needs of pharmacy businesses, policy makers will be able to respond more quickly and decisively.

Particular criticism should be laid at the door of NHSE&I. During the pandemic it became apparent that the hierarchy in the organisation perpetuated delays by quibbling over minor details resulting in the roll-out of initiatives and relaxations coming far too late. From the perspective of community pharmacy this appears to be a failing organisation.

What are the consequences of high national debt? What should the new fiscal rules be?
No response

The Spending Review was originally due in the Autumn 2019 but has now been postponed for more than a year. How robust is it in times of crisis?
It was good to hear the Chancellor recently announce that the core NHS budget will grow by £6.6bn as part of the Comprehensive Spending Review. That should enable DHSC and NHSE&I to invest in sustainable funding for community pharmacy to support its role in combatting COVID-19, illness prevention and improving healthcare outcomes. NHSE&I no longer has any excuse to say the funding is not there.

Much of the recent statement focussed, perhaps understandably, on short-term measures. However, given the parlous state of the finances in many pharmacy businesses this provides no comfort or assistance and will mean that investment decisions such as premises improvements or staff training will also be postponed.

It should also be highlighted that pharmacies could well be on the frontline if there are medicines supply issues post Brexit. Any disruption to funding flows to community pharmacy as a result of Brexit on top of the absence of any agreement about payment of pharmacy's COVID costs could well be critical for the network.

How effectively did the Government work with the Bank of England? Was fiscal and monetary policy well-co-ordinated? Do there need to be changes to the monetary and fiscal framework?
No response

What are the productivity challenges in the wake of the coronavirus crisis?

• How has the crisis impacted on innovation and technological development? What problems could technology solve and what problems will it cause?

People working in community pharmacies cannot work from home; their role is to serve patients and ensure that they get the medicines and advice they need at a convenient location for the patient. However, what the pandemic has shown is that there are a number of areas ripe for updating. For example:

- There needs to be a 'bonfire of bureaucracy' – there are large parts of the community pharmacy contractual framework which were suspended during the pandemic which now seem obvious that they serve no useful purpose. These need to be permanently removed from the framework. In addition, the pandemic ought to provide Government with the opportunity to look at the way it functions and ensure that it is set-up to make decisions with appropriate speed and governance.
- Supervision of pharmacy activities currently requires a pharmacist to be on the premises for most activities to occur. This is extremely restrictive in a pandemic situation. There are a limited number of activities that could occur safely without a pharmacist being present or being present remotely through the use of technology. The regulations governing this were introduced in 1968 and developed by subsequent legal cases. The DHSC have been looking at these issues for over a decade and they now need to proceed at pace with modernising the regulations to reflect the current practice in community pharmacy.
- A number of large community pharmacy operators, including ourselves, have invested in 'hub and spoke' dispensing. This involves details of the patient's prescription being sent to an automated hub where the items are assembled and shipped back to the pharmacy 'spoke' so the patient can collect them. This removes volume from the pharmacy allowing the pharmacy team to engage patients and deliver the new services the NHS wants pharmacies to deliver. Hub and spoke dispensing can only be carried out in the same legal entity. Enabling hub and spoke dispensing across legal entities has been on the agenda for at least the last 5 years. However DHSC has made little progress on achieving this following an aborted consultation process in 2016. Hub and spoke dispensing greatly relieved the pressure on our pharmacies during the pandemic and we believe that all pharmacies should be given the option to use hub and spoke dispensing even if they subsequently choose not to.
- Enabling Original Pack Dispensing would increase the volume of items which could be processed through hub and spoke facilities. Where a GP prescribes, for example, 30 tablets but the pack is produced in 28 tablets, the community pharmacy is required to 'snip' 2 tablets from another pack and add it to the pack of 28. Not only is this enormously inefficient and labour-intensive it also means that all of the safety seals on the pack have to be broken to add the 'snipped' 2 tablets leading to a reduction in the integrity of the pack. Again, the DHSC has been aware of this issue for many, many years and they now need to find a way to rectify this problem which not only allows increased automation to be used in the dispensing process but increases patient safety as the 'snipping' of tablets is often a source of error.
- General Practice began triaging patients very early in the pandemic which led to a significant (and unintended) increase in patients accessing community pharmacy. Whilst the NHS will rightly celebrate the digital transformation in GP primary care this has, in turn, moved thousands of patients and more complicated patient scenarios into community pharmacy. This adds pressure both through the level of training needed by pharmacy teams but also the efficiency with which large numbers of patients can be managed. Whilst this is within the capability of the sector and part of the NHSE&I desired transformation of practice, this work is currently unfunded risking long-term viability. There needs to be an appreciation, when

considering innovation, of the impact on linked environments such as between GPs and community pharmacies.

- When patients were displaced during the pandemic and either started collecting prescriptions closer to home or moved out of cities to the family home it quickly became apparent that NHS infrastructure is severely lacking:
    - There is no single patient record with role-based access. This means when patients change pharmacy a new record for them is created in the new pharmacy they have chosen. In addition while GPs are restricting access we are seeing significant numbers of displaced patients attending the pharmacy for some serious issues. The Summary Care Record is available but is very limited in scope and often does not hold the information required to make clinical decisions. Without access to key pieces of information pharmacists are dependent upon the patient for information or, in some cases, are 'flying blind'. A similar story is true for GPs and hospitals. The technology to create a single patient record exists; all that's required is the inclination to create it in the cloud.
    - The technology underpinning the Electronic Prescription Service has reached the end of its life. For example if a pharmacy closed due to a COVID outbreak it was extremely difficult and sometimes impossible to retrieve a prescription in another pharmacy to enable the patient to get their medicines. A new EPS is therefore required and should also be built into the single patient record referred to above.
- The apprenticeship levy is key to ensuring businesses have the skills and workforce for the future. What is needed to fully utilise this scheme is greater flexibility in the use of the funds and without 'sun-setting' the funding. Despite the extenuating circumstance of the pandemic there have been problems extending the sunset deadline.
- Wholesale productivity has been affected due to social distancing and other covid secure measures that have to be made in order to operate.
- Office productivity has benefitted from a more general approach to flexible working with many colleagues working in a balance work from home and office manner.
- Greater use and understanding of remote working technology has reduced hugely the travel miles travelled across the economy, remote auditing methods have been adopted significantly reducing costs.
- Reduced socialisation and increased isolation of colleagues has reduced some colleagues output and endangered mental health. This has been noted across the economy.
- Congestion on roads has significantly decreased, reducing journey times both to and between work places, with the consequent reduction in pressure on car parking and other similar utilities.

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