House of Commons

Health and Social Care Committee

Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England

Tenth Special Report of Session 2022–23

Ordered by the House of Commons to be printed 19 July 2023

HC 1310
Published on 25 July 2023
by authority of the House of Commons

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

Steve Brine MP (*Conservative, Winchester*) (Chair)

Lucy Allan MP (*Conservative, Telford*)

Paul Blomfield MP (*Labour, Sheffield Central*)

Paul Bristow MP (*Conservative, Peterborough*)

Martyn Day MP (*Scottish National Party, Linlithgow and East Falkirk*)

Chris Green MP (*Conservative, Bolton West*)

Mrs Paulette Hamilton MP (*Labour, Birmingham, Erdington*)

Dr Caroline Johnson MP (*Conservative, Sleaford and North Hykeham*)

Rachael Maskell MP (*Labour (Co-op), York Central*)

James Morris MP (*Conservative, Halesowen and Rowley Regis*)

Taiwo Owatemi MP (*Labour, Coventry North West*)

Powers

© Parliamentary Copyright House of Commons 2023. This publication may be reproduced under the terms of the Open Parliament Licence, which is published at www.parliament.uk/site-information/copyright-parliament/.

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hsccom and in print by Order of the House.

Committee staff

The current staff of the Committee are Joanna Dodd (Clerk), Lucy Durham (Clinical Fellow), Sandy Gill (Committee Operations Officer), Libby McEnhill (Senior Committee Specialist), James McQuade (Committee Operations Manager), Stephen Naulls (Clinical Fellow), Anne Peacock (Media and Communications Manager), Yohanna Sallberg (Second Clerk), Emma Stevenson (Committee Specialist), Katherine Woolf (Parliamentary Academic Fellow), and Catherine Wynn (Committee Specialist).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

You can follow the Committee on Twitter @CommonsHealth

Contents

Report from the Committee's Expert Panel on pharmacy in England 2

The Committee's Expert Panel 2

The Expert Panel's evaluation 2

Introduction 5

Executive Summary 8

1 Community pharmacy 28

2 Integrated care (including patient safety) 50

3 Hospital pharmacy 74

4 Workforce education and training 89

5 Extended services 105

Annex A: Anchor statements for CQC-style ratings 116

Annex B: Published written submissions 117

Annex C: Transcripts 119

Report from the Committee's Expert Panel on pharmacy in England

The Committee's Expert Panel

1. In 2020, we established and commissioned a panel of experts (known as the Expert Panel) to evaluate—independently of us—progress the Government have made against their own commitments in different areas of healthcare policy. The framework for the Panel's work was set out in our Special Report: Process for independent evaluation of progress on Government commitments (HC 663), published on 5 August 2020. The Expert Panel has previously published five evaluations on the Government's progress against its policy commitments in the area of:

- Maternity services in England, published on 6 July 2021 (HC 18),
- Mental health services in England, published 9 December 2021 (HC 612),
- Cancer services, published on 30 March 2022 (HC 1025), and
- The health and social care workforce, published 25 July 2022 (HC 112).
- The digitisation of the NHS, published 17 February 2023 (HC 780)

2. The Core members of the Expert Panel are Professor Dame Jane Dacre DBE (Chair), Professor Emma Cave, Professor Anita Charlesworth CBE, Sir Robert Francis KC, Sir David Pearson and Professor Stephen Peckham.

3. We asked the Expert Panel to undertake its sixth evaluation into the Government's progress against its policy commitments in the area of the pharmacy services in England. For this evaluation, the core Expert Panel members were joined by pharmacy specialists Nadra Ahmed CBE, Mark Lyonette, Dr Rima Makarem, Dr Hamde Nazar, Dr Raliat Onatade, Ellen Williams, and Dr Michael Twigg.

4. We thank the members of our Expert Panel for their work and the important contribution they have made in support of the Committee's scrutiny of the Department of Health and Social Care.

The Expert Panel's evaluation

5. With our agreement, the Expert Panel focussed on the following policy areas:

- Community pharmacy
- Integrated care (including patient safety)
- Hospital pharmacy
- Workforce education and training
- Extended services.

6. The Expert Panel's evaluation is appended to this Report. Although its evaluation was undertaken without input from the Committee, we expect the Department to respond to it within the standard two-month period for responses to Select Committee reports.

The Health and Social Care Committee's Expert Panel:

Evaluation of the Government's progress against its policy commitments in the area of pharmacy in England

Introduction

Governments often make well-publicised policy commitments with good intentions to improve services for the public. While such policy commitments can be made frequently, it is often difficult to evaluate or monitor the extent to which these commitments have been, or are on track to be, met. For this reason, formal processes of evaluation and review are essential, not only to hold the Government to account, but to allow those responsible for policy implementation to critically appraise their own progress; identify areas for future focus; and to foster a culture of learning and improvement. Such a process can also promote improvements in the quality of the commitments made.

Improvement and review are iterative processes during which the impact and success of innovations are identified, modified, and reviewed and this discipline is already in good use within the NHS. The concept has also been used successfully including in health and social care, by the Care Quality Commission (CQC). To apply this approach to health policy, the House of Commons Health and Social Care Select Committee established a panel of experts to support its constitutional role in scrutinising the work of the Government. The Panel is chaired by Professor Dame Jane Dacre DBE and is responsible for conducting politically impartial evaluations of Government commitments in different areas of healthcare policy. The Panel's evaluations are independent from the work of the Committee.

The Expert Panel produces a report after each evaluation which is sent to the Committee to review. The Panel's report is independent. The final report includes a rating of the progress the Government have made against achieving their own commitments. This is based on the "Anchor Statements" (see Annex A) set out by the Committee. The intention is to identify instances of successful implementation of Government pledges in health and social care as well as areas where improvement is necessary, and to provide explanation and further context.

The overall aim is to use this evidence-based scrutiny to feed back to those making promises so that they can assess whether their commitments are on track to be met and to ensure support for resourcing and implementation was, or will be, provided to match the Government's aspirations. It is hoped that this process will promote learning about what makes an effective commitment, identify how commitments are most usefully monitored, and ultimately improve health and care.[1]

Where appropriate, the Panel will revisit and review policy commitments to encourage sustained progress. The Expert Panel's remit is to assess progress against the Government's key commitments for the health and care system rather than to make policy recommendations. This is the sixth report of the Expert Panel and evaluates the Government commitments made in the area of pharmacy services in England.

1 During a roundtable with stakeholders during a previous evaluation, we heard that the term "service user" was not a preferred term in the social care sector, and that we should instead refer to those receiving social care as "people in receipt of social care". We have therefore chosen to do so in the text, but quotes and statistics which use the term "service user" will appear in the text where they have done so in the original sources.

Members of the Expert Panel

The Expert Panel is chaired by Professor Dame Jane Dacre DBE and is comprised of core members and subject specialists. Core panel members were recruited for their generic expertise in policy, with a broad understanding of qualitative and quantitative research methods, and the evaluation of evidence. Subject specialists were recruited to bring direct experience and expertise to the area under evaluation by the Expert Panel. All Expert Panel members have been officially appointed by the House of Commons Health and Social Care Select Committee.

Core members of the Expert Panel are:

- Professor Emma Cave,
- Professor Anita Charlesworth CBE,
- Sir Robert Francis KC,
- Sir David Pearson, and
- Professor Stephen Peckham.

Pharmacy specialist members of the Expert Panel are:

- Nadra Ahmed CBE,
- Mark Lyonette,
- Dr Rima Makarem,
- Dr Hamde Nazar,
- Dr Raliat Onatade,
- Ellen Williams, and
- Dr Michael Twigg.

Further information on the Expert Panel is set out in the Health and Social Care Committee Special Report: Process for independent evaluation of progress on Government commitments (5 August 2020).[2] The latest information relating to the Expert Panel can be found here: The Health and Social Care Committee's Expert Panel (shorthandstories.com).

Members of the Expert Panel secretariat

- Joanna Dodd
- Lucy Durham
- Sandy Gill

2 The Health and Social Care Select Committee, Process for independent evaluation of progress on Government commitments HC 663 (August 2020)

- James McQuade
- Yohanna Sallberg
- Professor Katherine Woolf

Acknowledgements

We would like to thank the Department of Health and Social Care and NHS England for their engagement with our evaluation. We would like to extend our thanks to those who have supported our work, and especially those who took part in our roundtable discussions. The testimonies they provided have been a great asset in our evaluation process, and we thank them for their involvement and their candour. We would also like to thank the various organisations, interest groups and individuals who provided written evidence to our evaluation, and for the quality and detail of their submissions. These submissions made a significant contribution to the Panel's evaluation of pharmacy services in England.

Executive Summary

The Health and Social Care Committee commissioned a review of the evidence for the effective implementation and appropriateness of the Government's policy commitments relating to pharmacy services in England. This report has been produced independently of the Committee's pharmacy inquiry. The findings and ratings, however, may contribute to the Committee's inquiry on this topic.

The Expert Panel consists of core members with recognised expertise in quantitative and qualitative research methods, and policy evaluation. This core group was complemented by experts with research expertise in, and practical experience of pharmacy services in England.

Evaluations and judgements in this report are summarised by ratings which assess the Government's progress against specific commitments made regarding pharmacy services in England.

The ratings in this report are in the style used by national bodies such as the Care Quality Commission (CQC), however they have been determined by us and do not reflect the opinion of the CQC or any other external agency. The commitments under review are interconnected, allowing an overall rating to be made which forms a combined assessment against all the commitments we evaluated. Separate ratings have also been given to each commitment and its main components. All ratings are informed by a review process using a combination of established research methods, expert consensus, and consultation with communities.

Our approach to this evaluation was to review quantitative and qualitative data provided by the Department and relevant non-departmental public bodies invited to contribute to the evaluation, alongside relevant research evidence to establish causative links, as well as evidence from other sources via a call for written submissions. We also heard from pharmacy professionals, patients, researchers, people in receipt of social care and advocates. Sources are referenced in footnotes throughout the report.

Selected Commitments

The Department provided the Expert Panel with the Government's recent policy commitments in the area of pharmacy services in England.[3] Using this information and wider policy documentation, we identified nine commitments across five broad policy areas. These included important and measurable ambitions for pharmacy services in England. We consider these commitments to provide reasonable generalisable evidence of progress against policy aspirations in the broader area of pharmacy services in England. We evaluated the Government's progress against these commitments.

3 Letter from the Parliamentary Under-Secretary of State for Primary Care and Public Health Neil O'Brien MP to the Chair of the Health and Social Care Committee and Jane Dacre, 3 April 2023

The commitments we have chosen to examine are:

Policy Area	Government Commitment
Community pharmacy	Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS. Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery.
Integrated care (including patient safety)	Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E. Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service').
Hospital pharmacy	To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024. To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation.
Workforce education and training	A further 3-year programme of education and training for PCN [Primary Care Network] and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists. Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists.
Extended services	Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF.

For each of the nine commitments under review, the Health and Social Care Committee approved the main questions to guide our evaluation. We developed a set of sub-questions relating to specific areas of the commitment. These main questions and sub-questions were incorporated into a final framework referred to as the Expert Panel's planning grid.

The main questions set out in the planning grid are:

- Was the commitment met overall? Or is the commitment on track to be met?
- Was the commitment effectively funded (or resourced)?
- Did the commitment achieve a positive impact for patients and people in receipt of care?
- Was it an appropriate commitment?[4]

Our approach was not a formal technical evaluation of the impact of different interventions on the policy aspirations and should not be viewed as a substitute for Government commissioned evaluations via the National Institute for Health and Care Research (NIHR). We shared the planning grid with the Department, inviting them to respond to all main questions and sub-questions in its formal written response. We identified key stakeholders and invited them to submit their own written response to the planning grid. We invited pharmacy professionals, people who regularly access pharmacy services for themselves or someone else, and advocates for people in receipt of social care and patients, to roundtable events, using discussion prompts informed by the planning grid.

We used the Department's response, which we received on 19 May 2023, key questions in the planning grid, as well as our own thematic analysis of 34 written submissions, publicly available data, and transcripts from roundtable events with 45 participants as the basis for this evaluation.

Responses were analysed using a framework method for qualitative analysis in health policy research.[5] The integration process of all quantitative and qualitative evidence was based on Pawson's 'realist synthesis' framework of evaluating policy implementation in healthcare settings.[6]

Overall rating across all commitments

Requires improvement

The overall rating across all commitments is 'requires improvement'. The ratings for the nine commitments across the five policy areas and main questions were used to inform our overall rating for the area of pharmacy services. The ratings for each of the nine commitments in the five policy areas are summarised in the following tables.

4 First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments (July 2020), p. 3

5 Gale, N.K., Heath, G., Cameron, E., Rashid, S., and Redwood, S. "Using the framework method for the analysis of qualitative data in multi-disciplinary health research", BMC Medical Research Methodology, vol 13 (2013) pp. 1–8

6 Pawson R. 'Evidence-based Policy: The Promise of `Realist Synthesis''. Evaluation, vol 8(3), (2002) pp. 340–358; Pawson, R., Greenhalgh, T., Harvey, G., and Walshe, K. "Realist review—a new method of systematic review designed for complex policy interventions". Journal of Health Services Research and Policy, vol 10 (2005) pp. 21–34

Community pharmacy

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS.	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery.	Inadequate	Good	Requires Improvement	Good	Requires Improvement

Integrated care (including patient safety)

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E.	Good	Requires improvement	Good	Good	Good
Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service').	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Hospital pharmacy

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024.	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation.	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement

Workforce education and training

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists.	Requires improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists.	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Extended services

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF.	Good	Requires improvement	Requires improvement	Good	Good

The overall rating for the nine commitments across the five policy areas evaluated is: Requires Improvement

This rating relates to the Government's progress overall against the nine commitments across the five policy areas based on guidance outlined in the anchor statements (Annex A) set out by the Health and Social Care Committee.

We chose five policy areas to evaluate:

1) Community pharmacy,
2) Integrated care (including patient safety),
3) Hospital pharmacy,
4) Workforce education and training, and
5) Extended services.

These policy areas cover pharmacy services delivered by community pharmacies, in hospital, and in primary care. We chose commitments that allowed us to examine progress on the Government's delivery of its ambition, as outlined in the NHS Long Term Plan, to increase the role of pharmacies and pharmacy professionals in healthcare.[7] Of the 43 pledges listed by the Department in their correspondence to us, 39 were included in the Community Pharmacy Contractual Framework (CPCF), a five-year funding deal for community pharmacy agreed in 2019 between the NHS, DHSC and the Pharmaceutical Services Negotiating Committee (PSNC[8]).[9] Seven of the nine commitments we chose to evaluate were from the CPCF. We also selected two additional commitments from outside of the CPCF which we identified as important to the delivery of safe and effective care in hospital.[10]

We recognise the significant progress made in some areas of pharmacy services. In particular, the evidence we received led us to rate the commitment to deliver a Community Pharmacist Consultation Service (CPCS) as 'good'. This commitment sets an expectation on community pharmacy to provide advice and medication for patients referred from NHS 111, and more recently, from General Practice, and since May 2023 from Urgent and Emergency Care. We also rated as 'good' the commitment to pilot prevention and detection services through the Pharmacy Integration Fund (PhIF) with a view to mainstream effective services through the CPCF.

It was, however, clear from the evidence we received that demand for community pharmacy services has increased significantly and that as a result, community pharmacies are struggling to deliver services, or even to remain open, within the existing funding

7 NHS England, The NHS Long Term Plan, August 2019
8 At the time of their submission, Community Pharmacy England (CPE) was transitioning to this name from their previous name, Pharmaceutical Services Negotiating Committee (PSNC). In the report, they are therefore referred to as PSNC, both in the text and in the footnotes.
9 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24, July 2019
10 Letter from the Parliamentary Under-Secretary of State for Primary Care and Public Health Neil O'Brien MP to the Chair of the Health and Social Care Committee and Jane Dacre, 3 April 2023

model (the CPCF). We conclude that the commitment to review the funding model has not been met. This, together with funding issues experienced by some community pharmacies alongside increased costs and demand, has had a negative impact on other commitments across multiple policy areas.

In our most recent evaluation, we rated progress on digitisation of the NHS in England as 'inadequate'. Within that evaluation we heard how many health and social care organisations experienced issues in ensuring a basic, adequate level of digital maturity, due to lack of funding and inadequate numbers of trained staff.[11] The evidence we received for this evaluation similarly indicated that poor digital maturity within Trusts and community pharmacies hampered the progress in meeting commitments. This was particularly the case for the commitments in the policy areas of Integrated care (including patient safety), Extended services, and Hospital pharmacy. We also heard evidence indicating that IT systems were typically inadequate for sharing patient information efficiently between community pharmacies and hospitals and general practice, which contributed to poor uptake of services.

In all of our evaluations to date, particularly our evaluation of the health and care workforce, we have consistently found that workforce shortages and poor training of staff pose a significant challenge to delivering safe and effective health and social care services.[12] In this evaluation we found that workforce shortages in hospitals and community pharmacies, inadequate training opportunities, increased costs of employing locum (temporary) staff to free-up time for training, and high staff turnover rates in general practice, were significant factors to commitments not being fully delivered. Some stakeholders and roundtable participants also suggested that the Additional Roles Reimbursement Scheme (ARRS), designed to incentivise PCNs to include additional roles (including pharmacists and pharmacy technicians) in their workforce by providing reimbursement, has resulted in staff shortages in community pharmacy as pharmacy professionals leave to take up ARRS funded roles in primary care. Furthermore, legislative changes aimed to improve the skill-mix within community pharmacy and thereby increase community pharmacists' capacity to deliver clinical services, have not been made. Based on the evidence we have received we conclude that even if, and when, these legislative changes are made, they are unlikely to achieve the desired aims without other additional actions to tackle the workforce challenges experienced within community pharmacy and, importantly, without additional legislation in medicines regulation.

Across several of the policy areas we evaluated there was a lack of robust evidence on the impact of the commitments on patients and people in receipt of social care. Stakeholders pointed to the potentially negative impact of community pharmacy closures in areas with high levels of deprivation, for people who rely on pharmacy services. Another concern expressed by some stakeholders was regarding those individuals who are exempt from prescription charges were being referred to community pharmacies from GPs, NHS 111 and Urgent and Emergency Care settings via the CPCS. If those individuals then needed

11 As per our previous report on the digitisation of the NHS, we consider digital maturity to include the extent to which providers are able to use digital technology to support the delivery of care, as well as the extent to which they have the infrastructure to support those digital capabilities. The Health and Social Care Committee, The Health and Social Care Committee's Expert Panel: Evaluation of Government commitments made on the digitisation of the NHS HC 780 (February 2023)

12 The Health and Social Care Select Committee, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of the health and social care workforce HC 112 (July 2022)

medication as a result of the referral, they would have to buy that medication over-the-counter from the pharmacy (or return to the GP for a prescription, defeating the object of the CPCS); whereas if they had seen a doctor rather than being referred directly to a pharmacy, they could have been prescribed medication for which they did not have to pay. Robust data, including from independent evaluations of initiatives, are necessary to identify and mitigate concerns about potential negative and unintended consequences of initiatives.

We note the Department and NHS England's Delivery plan for recovering access to primary care published on 9 May 2023. The plan includes commitments to increase the services offered by pharmacies, to deliver legislative changes to improve the skill mix within community pharmacy and to improve dispensing efficiency, as well as to maintain and expand the number of pharmacists working in primary care networks.[13] Furthermore, in July 2023 NHS England and DHSC published the NHS England Long Term Workforce Plan. Both of these plans were published subsequent to our call for evidence in relation to this evaluation, and as such we are not able to cover the impact of any new commitments made within the plans in this report.

We want to acknowledge the impact of the Covid-19 pandemic which presented exceptional challenges for pharmacy professionals working in all areas of health and social care. For example, many stakeholders described how community pharmacies had remained open during the pandemic and had implemented new ways of working to ensure patient and staff safety, often without additional funding. Demand for healthcare has grown since the pandemic, as has the costs of delivering care, whilst many parts of the country are also experiencing staff shortages. We want to express our gratitude for the huge efforts made by all staff working in all areas of pharmacy services, and within the health and social care sectors more widely, who continue to work tirelessly under sometimes challenging circumstances.

Overall, despite good performance in some areas, the evidence we received has led us to rate the Government's progress in the area of pharmacy services as 'requires improvement'. The rationale to support the rating and our findings for each of the selected commitments is summarised below.

13 DHSC 'Delivery plan for recovering access to primary care' May 2023

Community pharmacy

Commitment 1: Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS. (Requires improvement)

- We found that the commitment to maintain a Pharmacy Access Scheme (PhAS) has been met. The PhAS was introduced in 2019 and reviewed most recently in 2022.
- Stakeholders told us about increasing numbers of community pharmacies closing, and many having to reduce their opening hours which could restrict access to community pharmacy services out-of-hours and at weekends. We are concerned about how this could affect communities in deprived areas where the healthcare needs are likely to be high.
- The Department told us that pharmacies in receipt of support through the PhAS were less likely to close than those that were not in receipt of the payment. However, there is insufficient evidence about the impact the PhAS is having on maintaining access, including for people living in areas with fewer community pharmacies. Some of the Integrated Care Boards (ICB) and Integrated Care Systems (ICS) who provided evidence to us stated that they did not have access to data to enable them to evaluate the impact of the PhAS on pharmacies within their system.
- PhAS funding is fixed until the next review of the scheme and is included within the overall total funding amount (the 'global sum') allocated for community pharmacy under the CPCF. As a result the PhAS may not be enough to ensure that pharmacies are able to maintain their opening hours, and some may struggle to stay open. The commitment is too narrow in scope to address the major funding challenges faced by community pharmacy providers that are leading to closures. We therefore consider that the PhAS is likely to be insufficient to protect access to local pharmaceutical services in areas with fewer pharmacies.

Commitment 2: Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery (Requires improvement)

- The Community Pharmacy Commitment Framework (CPCF) was agreed in 2019 and the overall sum was fixed for five years. There was widespread agreement amongst the stakeholders we heard from that a review of the funding model is needed.
- However, although the Department stated that the funding model is constantly under negotiation and review, it was clear from the evidence we received that

most stakeholders did not consider that an appropriate review has taken place, with two describing the funding model as "broken". As such, we consider that the commitment has not been met.

- We received little evidence about the impact of the commitment on patients and people in receipt of social care. Several stakeholders commented that the current funding model has a negative impact on providers and therefore on patients and people in receipt of social care.
- The major criticism from stakeholders about the current funding model was that the overall amount of funding agreed for community pharmacy in 2019 has not been adjusted to take into account the additional demands, increased costs, and workforce issues faced by some providers. The amount of funding within the contract had assumed efficiencies in dispensing, but the Department accepts that these efficiencies have not occurred.
- We are concerned that the unreviewed funding model has resulted in community pharmacies being unable or unwilling to deliver additional clinical services; patients being unable to access some medications; and reduced access to community pharmacies, particularly in deprived areas.

Integrated care (including patient safety)

Commitment 1: Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E (Good)

- The commitment has been met and the Community Pharmacist Consultation Service (CPCS) has been delivered. We heard that the CPCS was enabling community pharmacy to support more people with minor conditions and freeing up capacity within other parts of the health service to manage more complex conditions.
- Referral pathways within NHS 111 are well established; however, the number of referrals coming through from general practice was uneven across the country, which limited the service's potential to achieve positive impact. This is largely due to uneven provision of IT systems that has made implementing the service cumbersome for some organisations. This has been compounded by workforce issues including lack of trained staff and staff shortages. Referrals from UEC (Urgent and Emergency Care) settings started in May 2023 following variable success in pilots.
- CPCS receives funding and investment from NHSE via the CPCF. ICBs and Local Pharmaceutical Committees (LCPs) can also provide local funding. Some of the evidence we received suggested that this funding is insufficient to deliver the service, given the scale of the IT, and workforce, challenges.
- We are concerned that people who are exempt from prescription charges may not benefit from a service that refers them directly to community pharmacy if they then need to purchase medication over-the-counter from the pharmacy, rather than obtaining it on prescription free of charge.
- We consider the commitment to be appropriate, and stakeholders were positive about community pharmacy managing minor conditions and helping to free up other parts of the health service to manage patients with more complex conditions.

Commitment 2: Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service'). (Requires improvement)

- This commitment has not been fully met. While the Discharge Medicines Service (DMS) is working in some areas, there is considerable variation in the number of referrals that community pharmacies receive from different hospital Trusts, and this variation exists even between Trusts within the same ICS.
- Evidence from serval ICBs indicates that Trusts cannot always easily refer patients via the DMS due to staff shortages within their organisations, and because IT systems in hospitals are often incompatible with the systems used in community pharmacies.

- The DMS is an Essential service that community pharmacies must deliver. However, hospital Trusts are not required to deliver the service, and we are concerned that incentives for them to do so were insufficient to overcome the barriers to uptake. This limits the capacity for hospitals to work with community pharmacy in an integrated way.
- We received evidence highlighting the significant benefits the DMS can bring to the NHS and patients where implemented, as evidenced in pilot studies. However, the Department recognised that uneven uptake of the service has limited the benefits to patients. Worryingly, we received little evidence about the governance of the DMS and processes for ensuring risks and errors are reported, monitored and fed back to ensure learning.
- The commitment to introduce the DMS is not sufficient without also putting in place the support required to ensure its effectiveness.

Hospital pharmacy

Commitment 1: To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024. (Inadequate)

- This commitment will not be achieved by 2024, with only 3% of Trusts having achieved the commitment so far. Although the deadline for achieving the commitment has been postponed by the Government until 2026, the evidence available to us indicate that it is not likely to be met by this deadline either. The differing levels of digital capabilities, and infrastructure, within Trusts will likely continue to be an obstacle to progress on this commitment.
- The investment made available for this commitment has not enabled Trusts to eliminate paper prescribing, which to a large part seems to be due to inequity in allocations of funding between Trusts. Based on the evidence we have received we conclude that the digital infrastructure to support the roll-out of this commitment is not in place due to lack of investment.
- Digital prescribing is generally seen as a positive development, allowing better productivity and improved safety. However, we are not convinced that the possible risks associated with eliminating paper prescribing have been fully considered by the Government ahead of making this pledge, and we are therefore unsure whether these risks have been mitigated for. The commitment's aim of eliminating paper prescribing will not have a positive impact on all patient groups. In supplementary evidence to us this was acknowledged by the Department, and the target was revised as not being the aim in all care settings.
- We conclude that the original deadline for the commitment being evaluated was not appropriate. It was overly ambitious in the context of NHS digital capabilities and infrastructure, which is not ready for this radical change across Trusts.

Commitment 2: To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation. (Requires improvement)

- Many initiatives included in this commitment remain in pilot phase, and it was challenging for us to evaluate progress on it, however, we conclude that the commitment is still some way off from being met.
- The commitment is unlikely to be met due to a combination of practical challenges, including gaps in the workforce needed to deliver it. Although the Department provided detail on the process to prepare the workforce, introducing pilots ahead of ensuring there are adequate arrangements made for the workforce seems unlikely to be effective.
- At this stage in the pilot phase, and with the information available to us, it is unclear whether this model is viable and funding levels are adequate, or whether the estimated further £275m that will be requested in the future, will prove

sufficient.

- Despite staff productivity being cited as a possible benefit, little consideration seems to have been given to the staff operating the hubs, the numbers of staff required, and the training they need to do it.

Workforce education and training

Commitment 1: A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists (Requires improvement)

- Although some training and development is being offered, there are significant challenges in ensuring that organisations are able to take up the offer to undertake training. This includes the current high demand for Designated Prescribing Practitioners (DPPs) to supervise training, high pressure on services leaving little time to dedicate to training and development, and lack of funding to backfill roles when employees are away to undertake training.

- The evidence, as well as the Department's response to our evaluation, focused largely on the training of pharmacists. We are concerned that there does not seem to be evidence around what training and development is available across the pharmacy professional workforce in order to meet the future service demands, particularly in community pharmacy.

- The aim to upskill staff is appropriate, but we remain concerned about the barriers to success and the unintended consequences of the commitment. The increased training provision for independent prescribers has highlighted the specific issues of retention in community pharmacy. Many pharmacy professionals leave community pharmacies for work in PCNs once they have their independent prescribing qualification, or due to better working conditions in those primary care roles funded by the Additional Roles Reimbursement Scheme (ARRS).

- Training provision by itself is not sufficient if not matched by investment that enables employers to support staff to undertake and benefit from it. This echoes what we have heard in our previous evaluations in relation to workforce training.

- The commitment has the potential to benefit patients and people in receipt of care, as staff become more skilled and there are a higher number of independent prescribers across the country, increasing access and availability for those needing prescriptions and pharmacy services. However, the benefit to PCNs increasing their workforce thanks to the support of the ARRS funding comes at the expense of the community pharmacy sector who continue to lose staff.

Commitment 2: Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists (Inadequate)

- Encouraging skill mix and better use of clinical skills in pharmacies is a positive initiative, however insufficient progress has been made on proposing the legislative changes promised in the commitment. The legislative changes needed are not clearly set out, and there seems to be uncertainty in the sector about what to expect and when. It is therefore challenging to monitor progress and to hold the Government accountable on its progress.

- We are concerned about the effect on community pharmacies as the Government delegates more tasks to them, without the legislation to enable them to use staff more efficiently. This is concerning, as many community pharmacies are in financial difficulty.
- If met, the commitment could deliver positive impacts for patients and people in receipt of social care, as appropriate training to maximise the knowledge and skills of all pharmacy professionals could deliver a better service. However, the delay in introducing the legislation whilst pharmacy providers have begun to introduce the services agreed in the CPCF, risks having a negative impact.
- We are concerned that, although the intention of this commitment is appropriate, in isolation, the commitment will not deliver the skill mix it envisions.

Extended services

Commitment: Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF. (Good)

- This commitment has been met. Three prevention and detection services have been piloted through the Pharmacy Integration Fund (PhIF) and subsequently rolled out through the CPCF. Most of the NHS organisations that submitted evidence confirmed that they have engaged with pilots and/or one of the mainstreamed services.

- The funding and infrastructure for pilots was deemed adequate. However, the global sum within the CPCF has not been supplemented with extra funding to support the extra mainstreamed services. We are concerned that, as a result of this, the provision of additional prevention and detection services "dilutes" the global sum and reduces the payments available for dispensing. Stakeholders also reported that a lack of funding for IT infrastructure and workforce limited their ability to deliver these services.

- The provision of prevention and detection services in community pharmacy has the potential to positively impact on people using the service. However, the evaluations of pilots are not readily available, which led us to conclude that the positive impact of this commitment has not been demonstrated and therefore requires improvement.

- Community pharmacies are appropriately placed to deliver prevention and detection services and it is sensible to pilot new services prior to national rollout. However, we remain concerned about the lack of outcome data. We are also concerned that the lack of resourcing in terms of funding, workforce and IT infrastructure limits the delivery of these services. Some stakeholders we heard from suggested that the commitment could be more specific and ambitious, to realise the maximum potential of these services.

A full list of the written evidence we received is included at the end of the report (see Annex B).

Evidence from the Department

- Additional written information received from the Department

Evidence from stakeholders:

- 34 written submissions.

Roundtable events

- Roundtable events with 45 participants with experience of pharmacy services in England from the perspective of pharmacy professionals, patients or people in receipt of social care and advocates for patients and people in receipt of social care.

This report provides an analysis of all information provided. The analysis is structured around the four overall policy areas which covered nine individual commitments, and the main questions (A-D) within each commitment.

1 Community pharmacy

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS.	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery.	Inadequate	Good	Requires Improvement	Good	Requires Improvement

In this section we provide an assessment of Government commitments in relation to community pharmacy. Two commitments were selected for evaluation:

"Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Contractual Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS."

"Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery."

Both commitments under evaluation in the area of community pharmacy are from the CPCF. The CPCF (2019–2024) was agreed in July 2019 by NHSE, the Department and the PSNC, and came into force in October 2019, providing funding of nearly £2.6 billion over five years for community pharmacy. According to NHSE, the five-year CPCF (2019–2024) outlined a vision for community pharmacy to have a greater role in delivering clinical care and prevention services, and to relieve pressure on general practice and urgent care.[14] Each year the detail of the funding is negotiated by the PSNC, NHSE and the Department. The last year of the five-year CPCF: year 5 (2023/24) was agreed in September 2022.[15]

A House of Commons Library briefing on the Future of Community Pharmacies published in June 2022 explained that community pharmacies must deliver services categorised as 'Essential' and can opt to also provide services that are 'Advanced', 'Enhanced' or 'Locally Commissioned':

- Essential services include dispensing medicines and appliances, providing advice on self-care and promoting healthy lifestyles.
- Advanced services, such as the provision of Medicine Use Reviews, or offering NHS flu vaccinations.
- Enhanced services, such as anticoagulation monitoring.
- Locally commissioned services, such as smoking cessation services or other public health services commissioned by local authorities.[16]

Commitment 1: Protect access to local pharmaceutical services

Overall Commitment Rating and Overview of commitment to protect access to local pharmaceutical services. Rating: Requires Improvement

This commitment seeks to ensure the population has access to community pharmacy services. The commitment sets out that access to local NHS pharmaceutical services in areas where there are fewer pharmacies will be protected by maintaining and improving the PhAS. According to the NHS Business Services Authority, the PhAS is designed to improve access to community pharmacy services by providing additional funding to the pharmacies most important for patient access and whose closure would affect patient and public access to community pharmacy.[17]

The PhAS replaced an earlier scheme called the Essential Small Pharmacies, Local Pharmaceutical Services (ESPLPS) scheme, which ended in 2017.[18] According to a 2019 report by the House of Lords Select Committee on the Rural Economy called 'Time for a strategy for the rural economy', the ESPLPS had sustained predominantly rural pharmacies that would otherwise not have been financially viable. The report quoted the PSNC which called for a "credible successor" to the scheme "to safeguard patient access to smaller pharmacies in rural areas, with additional funding".[19]

14 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)
15 Pharmaceutical Services Negotiating Committee, "Contractor Announcement: CPCF arrangements for 2022/23 and 2023/24 agreed", 22 September 2022
16 House of Commons Library Research Briefing, Future of Community Pharmacies (June 2022)
17 NHS Business Services Authority, What is the Pharmacy Access Scheme (PhAS)?, accessed 240423
18 Pharmaceutical Services Negotiating Committee, "The Essential Small Pharmacies, Local Pharmaceutical Services (ESPLPS) scheme", accessed 190623
19 House of Lords Select Committee on the Rural Economy, Report of Session 2017–19. Time for a strategy for the rural economy, HL Paper 330

The commitment was first set out in year 1 of the CPCF (2019–2024), published in July 2019, and has also appeared in years 2 and 3 of the CPCF:

- Year 1 of the CPCF, published July 2019, stated that the PhAS would be reviewed from 1 April 2020 in light of planned reductions in the costs of dispensing and increases in clinical services.[20]
- Year 2 of the CPCF, published February 2020, stated that a revised PhAS would be introduced in April 2021 following a full review.[21]
- Year 3 of the CPCF, published August 2021, stated that a new revised PhAS would start in January 2022 with the first payments being made in April 2022.[22] This is the most recent review of the PhAS.

The 2022 PhAS review resulted in a reduction of funding for the scheme from £24m to £20m. According to a PSNC contractor webinar from 2021, the PSNC sought this budget reduction because the PhAS is part of the overall budget (global sum) agreed for the CPCF. A higher sum allocated to the PhAS would therefore result in reduced funding elsewhere for community pharmacy.[23]

The revised PhAS is targeted at pharmacies more than one mile from the next nearest pharmacy (or more than 0.8 miles in the most deprived areas of the country). The amount of funding that eligible pharmacies receive depends on the volume of prescriptions they dispense.[24]

In 2022 there were 1445 pharmacies eligible for the PhAS.[25] An analysis of 11,738 community pharmacies in England by Professor Adam Todd and colleagues, published in the journal BMJ Open in 2018, suggests that rural and less deprived areas are most likely to have pharmacies eligible for the PhAS. The study found that only 6% of pharmacies in rural areas were close to (within 0.5 miles of) another pharmacy, compared to 81% of pharmacies in urban areas. Deprived areas were most likely to have several pharmacies close to one another.[26] The study's authors point out that, although having access to community pharmacy is important to health, the presence of a pharmacy does not necessarily mean it is able to provide services as required by the local population.[27] Similar points were made by participants in our roundtable discussions. One pharmacy professional questioned how access was defined within the PhAS:

> *"Access is an interesting thought, isn't it? Because what does access mean? Does it mean Monday to Friday? Does it mean when a GP surgery is open? Does it mean seven days a week? You know, what are the bus routes like? […]*

20 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24, July 2019
21 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 2 (2020 to 2021) , February 2020
22 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021
23 Pharmaceutical Services Negotiating Committee, http://cpe.org.uk/wp-content/uploads/2021/09/PhAS-contractor-webinar-21-Sept-2021, accessed 050623
24 NHS Business Services Authority, "2022 Pharmacy Access Scheme" accessed 050623
25 DHSC, Pharmacies eligible for the 2022 Pharmacy Access Scheme, accessed 080623
26 Todd, Thomson, Kasim and Bambra. "Cutting care clusters: the creation of an inverse pharmacy care law? An area-level analysis exploring the clustering of community pharmacies in England" BMJ Open, Volume 8, (2018) e022109
27 Todd, Thomson, Kasim and Bambra. "Cutting care clusters: the creation of an inverse pharmacy care law? An area-level analysis exploring the clustering of community pharmacies in England" BMJ Open, Volume 8, (2018) e022109

> *In rural places it can be a 10-minute journey in the middle of October and a two-hour journey in the middle of August."*[28]

Another participant explained how, despite having access to a pharmacy in a supermarket close to their home, that pharmacy was not able to provide the standard of care they needed, and so they chose to travel further to a small pharmacist with whom they had a good relationship:

> *"I travel quite some time, about eight miles, to a pharmacist that was a small pharmacist in a small town, that we got to know very well and got to know my mother-in-law very well. I found that at my local pharmacist, which is a big supermarket, I couldn't develop that personal relationship that that was required to navigate her medication regimes."*[29]

The trade body the Company Chemists' Association (CCA) argued that it is particularly important to protect access to community pharmacy in more deprived areas where access to other health services is often poorer.[30] In 2015, Professor Todd and colleagues looked at access to community pharmacy and access to general practice in England (defined as within 20 minutes' walk) by deprivation and rurality. They found that, in general, access to community pharmacy was better than access to general practice, and the areas with the best access to community pharmacy also had the best access to general practice. The most deprived areas, in both rural and urban parts of the country, had the best access to community pharmacy and to general practice. The areas with the worst access to general practice relative to their access to community pharmacy, were the better-off (less deprived) areas, particularly in rural parts of the country.[31] However, as stated above, distance to the nearest pharmacy or general practice is not, on its own, sufficient to assess whether a local population's healthcare needs are being met, particularly in deprived areas where needs may be particularly high. It also does not take into account the knock-on impact of pharmacy closures on other pharmacies and other local health services.

The CCA's analysis of NHS Digital Organisation Data Service data on pharmacies in England from 2015 to 2022 indicates that pharmacies in deprived areas may be at greater risk of closing. They found that 41% of pharmacy closures during the period were in the most deprived areas nationally whereas 9% of closures were in the least deprived areas. Overall, the CCA report suggests that there was a net loss of 670 community pharmacies (808 closed and 138 opened) with a peak in 2020/21 when 213 pharmacies closed.[32]

A House of Commons Library briefing on the Future of Community Pharmacies analysed data from the same source but over a shorter period (2017 to 2022). This briefing concluded that there had been 209 recorded closures in this time period, and a slight decrease in the number of pharmacies overall. The briefing did not provide an analysis of deprivation on area-level, but concluded that there was variability between NHS regions in the percentage of closures, ranging from 2.3% of pharmacies closing in the North West to 1.1% of pharmacies closing in the South West over the period.[33]

28 Stakeholder roundtables
29 Stakeholder roundtables
30 The Company Chemists Association, The impact of pharmacy closures on health inequalities, October 2022
31 Adam Todd, Alison Copeland Andy Husband, Adetayo Kasim, Clare Bambra. "Access all areas? An area-level analysis of accessibility to general practice and community pharmacy services in England by urbanity and social deprivation." BMJ Open, Volume 5, (2015) e007328
32 The Company Chemists Association, The impact of pharmacy closures on health inequalities, October 2022
33 House of Commons Library Research Briefing, Future of Community Pharmacies, June 2022

A participant in our roundtables indicated that community pharmacy closures had increased in recent months and were likely to increase further in 2023:

> *"[…] we believe closures have actually accelerated and we're likely to see a higher number of closures this year."*[34]

National figures of community pharmacy closures for 2023 are not currently available, however in January 2023 Lloyd's Pharmacy announced it was closing all of its 237 pharmacies within the supermarket Sainsbury's.[35] This includes 12 pharmacies eligible for the PhAS.[36] In June 2023 the company Walgreens Boots Alliance announced it was closing 300 branches of the pharmacy Boots across the UK (in addition to 150 Walgreens branches in the United States). The Financial Times reported that the announcement came as the pharmacy group significantly reduced its earnings forecast for the year, citing weaking demand for Covid-19 related products and consumers being more cautious about spending. The newspaper indicated that:

> *"Most closing Boots sites are located within 5km of another, with customers largely remaining within a 10-minute drive of an outlet."*[37]

At the time of publication of this report there is no further information about which stores are closing and whether any of them are in receipt of the PhAS.

We have given an overall rating for this commitment of 'requires improvement'. Although we conclude that the commitment has been met, in so far as it pledges to maintain a PhAS, we were concerned that the commitment is not broad enough in scope to include the need to protect community pharmacy services across all parts of the country. This extends to ensuring access out of hours and at weekends, and in the most deprived areas, where needs may be highest. We found little evidence of the impact of the commitment on patients or people in receipt of social care. The evidence we received indicated that the commitment was insufficiently funded or resourced to prevent community pharmacy closures. This is because the amount of funding for the scheme is included within the global sum for community pharmacy, and financial difficulties are resulting in pharmacies reducing their hours or even closing. Taken together, this evidence led us to rate the commitment as 'requires improvement' overall.

Was the commitment met overall (or on track)? Rating: Good

Most of the ICBs and LPCs that provided evidence to us, as well as the Royal Pharmaceutical Society (RPS) and the CCA, agreed that the PhAS had been maintained and revised in 2022. In that regard, we conclude that the commitment has been met.[38]

34 Stakeholder roundtables

35 Sky news, "Lloyds Pharmacy to close all Sainsbury's branches putting 2,000 jobs at risk, 19 January 2023

36 DHSC, Pharmacies eligible for the 2022 Pharmacy Access Scheme, accessed 190623

37 The Financial Times, "Boots and Walgreens to close 450 branches across UK and US", 27 June 2023

38 Anonymised (APE0007), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038), The Company Chemists' Association (APE0018), Community Pharmacy Suffolk LPC (APE0029), The Community Pharmacy Humber LPC (APE0032), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

In terms of whether the aspect of the commitment that is to "protect access to local physical NHS pharmaceutical services in areas where there are fewer pharmacies" has been met, the evidence we received was more variable. Two ICBs (NHS Black Country ICB and NHS Coventry and Warwickshire ICB) stated that the PhAS was working within their areas.[39] A third (NHS West Yorkshire ICB) was also positive, saying that revisions to the PhAS had resulted in more community pharmacies becoming eligible for the scheme, and no pharmacies in their area had closed since the 2022 PhAS revision.[40] NHS Bedfordshire, Luton and Milton Keynes ICB indicated that the PhAS supported 19% of pharmacies in their area and that the scheme was "essential to ensure rural communities have access to pharmacies".[41] Similarly, according to the Pharmacists' Defence Association (PDA), its members reported more closures and reduced opening hours in pharmacies that were not supported by the scheme.[42]

By contrast, six ICBs we received evidence from told us that they lacked data on the effectiveness of the PhAS, which made it difficult for them to know if the scheme was meeting the commitment aim.[43] Of those ICBs, two assumed the PhAS was working to protect access in rural areas because pharmacies in their ICS were eligible for the PhAS, and access to community pharmacy within their ICS was acceptable.[44] For example, NHS Nottingham and Nottinghamshire ICB stated:

> *"Within Nottingham and Nottinghamshire County Pharmaceutical Needs assessments the current Health and Wellbeing boards are satisfied that all residents can access a pharmacy within 20 minutes by private transport….. There are over 20 pharmacies in the NHS Nottingham and Nottinghamshire ICB who are on the list for eligibility for payment. […]it may be possible to extrapolate from this that the Pharmacy Access fund is working."*[45]

NHS Surrey Heartlands ICB, however, indicated that of 31 pharmacies in their ICS who receive PhAS payments, two were closing at the end of May 2023.[46] There were also indications from NHS Northamptonshire ICB, Bedfordshire Luton and Milton Keynes ICB, Humber LPC, Suffolk LPC, and Avon LPC that, although the PhAS had supported pharmacies within their areas, the scheme might not be sufficient to prevent closures and ensure access more generally due to other pressures faced by community pharmacies.[47] NHS Bedfordshire, Luton and NHS Milton Keynes ICB described how the eligibility criteria for the revised PhAS did not always result in the pharmacies that need funding getting it, and can also result in pharmacies prioritising dispensing over providing other services:

> *"The criteria used to determine eligibility for the PhAS may not always accurately reflect the actual need for pharmacy services in certain areas.*

39 NHS Black Country ICB (APE0014), NHS Coventry and Warwickshire ICB (APE0025), Community Pharmacy Suffolk LPC (APE0029)
40 NHS West Yorkshire ICB (APE0034)
41 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
42 The Pharmacists' Defence Association (APE0030)
43 NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Northamptonshire ICB (APE0023)
44 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Leicester, Leicestershire and Rutland ICB (APE0033)
45 NHS Nottingham and Nottinghamshire ICB (APE0013)
46 NHS Surrey Heartlands ICB (APE0006).
47 Avon LPC (APE0017), The Community Pharmacy Humber LPC (APE0032), Community Pharmacy Suffolk LPC (APE0029), NHS Northamptonshire ICB (APE0023)

> *There could be areas that face access challenges but do not meet the specific criteria, resulting in pharmacies in those locations not receiving the intended financial support. Despite the introduction of the Revised PhAS in January 2022, eligibility continues to be based on both the dispensing volume and distance from the next nearest pharmacy. This dissuades contractors to focus on other pharmacy activities and services".*[48]

Additionally, NHS Sussex Integrated Care pointed out that, although rural pharmacies were remaining open due to the PhAS, access to out-of-hours and weekend pharmacy services was not necessarily protected by the scheme.[49]

Two ICBs[50] welcomed the Department's commitment to continue to monitor and review the PhAS, by April 2023 at the earliest, as part of the CPCF.[51] Several other ICBs, as well as Avon LPC and the RPS, indicated that the PhAS needs further revision in light of increased pharmacy closures.[52] The CCA stated that there is a need for a holistic review of pharmacy access, arguing that access to community pharmacy in deprived areas is threatened.[53]

The Department's submission states that this commitment has been met in full. According to the Department's submission, since the PhAS launch, there has been a lower closure rate of pharmacies on the PhAS scheme compared to those not on the scheme. From the start of the 2022 scheme around 1,150 pharmacies were deemed eligible for the scheme (14% in areas of high deprivation) and 0.3% of pharmacies on the PhAS have permanently closed, compared with 1.6% of pharmacies which were not.[54]

Overall we conclude that the commitment to maintain a PhAS scheme has been met and therefore we have rated this aspect of the commitment as 'good'. This is notwithstanding mixed reports from stakeholders about whether or not the commitment to maintain access to local physical NHS pharmaceutical services in areas with the fewest pharmacies, has been met, in full, across the country, including access out-of-hours, on weekend, and in deprived areas.

Was the commitment effectively funded (or resourced)? Rating: Requires Improvement

Most stakeholders were negative regarding the funding levels of the PhAS. The major criticisms were that the PhAS is fixed until the next review and included within the global sum for community pharmacy. As such, they argued, the PhAS is not on its own sufficient to keep pharmacies open and accessible when they are struggling financially with increased levels of dispensing, workforce pressures and increases in costs due to rising inflation.[55]

48 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
49 NHS Sussex Integrated Care (APE0037)
50 NHS Black Country ICB (APE0014), NHS Coventry and Warwickshire ICB (APE0025)
51 DHSC, 2022 Pharmacy Access Scheme: guidance, updated May 2023
52 NHS West Yorkshire ICB (APE0034), NHS Northamptonshire ICB (APE0023), NHS Sussex Integrated Care (APE0037), Avon LPC (APE0017), NHS Surrey Heartlands ICB (APE0006), Royal Pharmaceutical Society (APE0038)
53 The Company Chemists' Association (APE0018)
54 Department of Health and Social Care (APE0039)
55 Professor Ian Maidment, Aston University (APE0004), NHS Surrey Heartlands ICB (APE0006), Anonymised (APE0007), NHS Suffolk and North East Essex ICB (APE0010), NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038), The Company Chemists' Association (APE0018), Community Pharmacy Suffolk LPC (APE0029), The Community Pharmacy Humber LPC (APE0032), Pharmaceutical Services Negotiating Committee (APE0009), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

A participant in one of our roundtables who lives in what they called a "semi-rural area", described the pressure that their small local community pharmacy is under to deliver services in the face of workforce shortages and drug shortages, and due to difficulties co-ordinating with the local GP (general practice) surgery, which dispenses medications to patients living further away ("dispensing patients"):

> *"I live in a semi-rural area, so we have a split, our GP surgery locally who deals with the dispensing patients, those that live more than 1.5, 1.6 kilometres away from the doctor's surgery, and then a small community pharmacy that deals with the rest. The pharmacy services they provide is a good service, as I've heard, to everybody. They're at full stretch because they're quite rural, they have full recruiting and so on. They provide as many services as is feasibly possible, but of course it is the workload and the sheer volume of work that they're getting through. And I think a lot of the issues arise around—especially over the last few years—drug shortages and changes and switches, that's what we've seen is our main problem around the workload, and the toing and froing between community pharmacy and GP services, which creates substantial extra work."*[56]

NHS Suffolk and North East Essex ICB expressed concern that the PhAS funding was not sufficient, but that increasing the funding from within the global sum allocated to community pharmacy would result in the sector having to fund reductions elsewhere. This would then adversely affect other pharmacy contractors already facing financial difficulties.[57] NHS Surrey Heartlands ICB indicated that the funding available via the PhAS was less than under the previous local pharmaceutical services (LPS) contract.[58]

Several stakeholders described how the amount of funding an eligible pharmacy receives under the PhAS depends on individual contractor's dispensing volume and distance from other contractors, the implication being that other pharmacies in need of funding may not receive it.[59] NHS Surrey Heartlands ICB also told us that the appeals process for pharmacies deemed ineligible was long.[60]

A stakeholder in our roundtable discussions told us that the PhAS eligibility criteria had not been properly worked out during the CPCF negotiations. They claimed that the scheme had only been included within the CPCF because of pressure from MPs in rural areas. According to this stakeholder, the PhAS eligibility criteria together with the fact that the PhAS is included within the global sum of the CPCF, has resulted in some pharmacies receiving PhAS funding they do not particularly need, while other non-eligible pharmacies close due to financial difficulties. This stakeholder believed that the PhAS should have been funded additionally, outside of the CPCF:

> *"…the premise of the concept of making sure everybody's got access and you don't leave gaps is absolutely fine. The challenge is, however you do that, is beneficial to some and not to others, and there is no easy route that weaves*

56 Stakeholder roundtables
57 NHS Suffolk and North East Essex ICB (APE0010)
58 NHS Surrey Heartlands ICB (APE0006)
59 NHS Dorset Integrated Care (APE0027), NHS Suffolk and North East Essex ICB (APE0010), NHS Surrey Heartlands ICB (APE0006), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040), Pharmaceutical Services Negotiating Committee (APE0009)
60 NHS Surrey Heartlands ICB (APE0006)

> *a way through that. So, an agreement was reached about how that should be, but, obviously, not everybody who receives Pharmacy Access funding is necessarily desperately in need of Pharmacy Access funding in order to provide the service that they do. So, I think there's a difference between the principle of making sure that everybody has access, and a lot of work has been done about where pharmacies are, there are clearly over-provided areas, but there are clearly some gaps, but obviously the regulations don't allow contracts to be awarded just anywhere. So, it's actually quite a complex thing. I think it's a bit of a blunt tool to solve what was anticipated as a problem which actually fell out of other regulatory changes and changes in the contract. So, it wasn't actually really in the negotiation ever at the time that the negotiation happened, but obviously it got put in because a lot of MPs in rural areas were really concerned about what might happen in their localities and it kind of got bolted onto the negotiations at the time. So, it wasn't really an intended solution to the problem. It was kind of, "how do we fix something that means everybody can agree and hopefully we'll unpick it later", but it's proven a bit harder to unpick than perhaps it is."*[61]

In their submission the PSNC stated that the fact that the PhAS is part of the global sum allocated to community pharmacy was "too much of a burden for the sector to accept" and indicated that the ICBs can fund pharmacies that are too small to be viable, from outside of the CPCF.[62] Humber LPC stated that a scheme financed via ICBs would be preferable to the current system.[63] NHS Coventry and Warwickshire ICB stated that the funding to date had been sufficient, but suggested that a review was needed given the increased financial pressures on community pharmacies, and also indicated that an increase in funding should come via ICBs:

> *"Given the current changes in the pharmacy market, we would welcome the scheme and funding being reviewed given the financial pressures on community pharmacies and this would need to be reflected in ICB budget allocations."*[64]

The Department's submission confirms that one of the intended aims of the revised PhAS is to prevent larger pharmacies from relying on the PhAS and to encourage growth for smaller pharmacies. The Department's submission argues that the current allocation of £20 million funding for the PhAS (from the overall CPCF funding envelope of £2.592 billion) is in line with the funding from previous years and has been agreed in consultation with the PSNC.[65]

We conclude that the funding aspect for this commitment 'requires improvement' based on the evidence we received that PhAS funding is fixed until the next review and included within the global sum for community pharmacy with the result that the PhAS may not be sufficient to ensure access among pharmacies that are struggling financially.

61 Stakeholder roundtables
62 Pharmaceutical Services Negotiating Committee (APE0009)
63 The Community Pharmacy Humber LPC (APE0032)
64 NHS Coventry and Warwickshire ICB (APE0025)
65 Department of Health and Social Care (APE0039)

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Requires improvement

Many ICBs and some LPCs were positive in their submissions about the intention of the PhAS and the need to protect access to community pharmacy and the benefits this would confer to patients.[66]

Several ICBs and Avon LPC reported a lack of data available to ascertain whether the PhAS had directly impacted patients.[67] The PDA stated that temporary closures of the pharmacies that are ineligible for the PhAS negatively impacts on patients, the assumption being that the PhAS has a positive effect by keeping eligible pharmacies open.[68] NHS Bedfordshire, Luton and Milton Keynes ICB indicated that the PhAS was essential to protect access to pharmacies in rural areas, but also indicated that despite the PhAS, community pharmacies have been closing, which had caused patients to struggle to access essential medications.[69]

Two stakeholders in one of our roundtables explained the important of keeping pharmacies open, especially in deprived areas where people are more likely to have complex health needs. However they stated that too many pharmacies in those areas were closing, resulting in increased pressure on the remaining pharmacies in those areas who receive no additional funding, as well as increased pressure on other healthcare services, with negative impacts on the local community:

> *"[…] pharmacies are closing in the areas that need them the most. In some parts of my local area we're seeing quite a lot of pharmacies which served the population really well have been closed by big multiples with no real explanation to the local population. And then patients are having to come back to general practice and asking who they should go to alternatively. But then it puts a pressure on the community pharmacies left in the area to take on board that work pressure. And there's no extra funding, but there's greater expectation that those pharmacies are going to meet the needs of the population who might have really complex health needs. I mentioned one specific part of my local area which has some of the highest levels of deprivation in the country. But we're having less and less pharmacy services facilitating the needs of those communities. And so yeah, that's been my experience in my local area in primary care. And I guess the same has been said as well of the neighbouring area which I work in and covers 111 services. Colleagues are seeing that, and ultimately it's affecting the local communities as well."*[70]

> *" […] I think one thing to highlight is the knock-on effect that the closures have on other services. So, patients who are unable to access pharmacies will*

66 Anonymised (APE0007), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), NHS Frimley Integrated Care (APE0020), NHS Northamptonshire ICB (APE0023), NHS Coventry and Warwickshire ICB (APE0025), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), Avon LPC (APE0017), Community Pharmacy Lincolnshire (APE0022), National Pharmacy Association (APE0026)

67 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), Avon LPC (APE0017).

68 The Pharmacists' Defence Association (APE0030)

69 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

70 Stakeholder roundtables

> *then either turn to the 111 service or general practice, or in some cases, the ambulance service. I'm a paramedic so I'm out there in my local area serving patients, and we're getting queries that are getting jumbled up through the system whereby patients are just looking for medication. Or in instances where we're trying to organise prescriptions for patients to prevent hospital admission, there's no access to the pharmacist to actually get them dispensed. We're dealing with an increased number of palliative care patients and that's where we can really hit problems in being able to access the end-of-life medication for patients, the morphine, the midazolam, hyoscines etc. So that's the kind of knock-on effect for us. The overall thing is, if there's an ambulance parked outside someone's house trying to sort a problem out, then that ambulance is not out responding to other people and medical emergencies, which is what we're trained to do. And hence we're seeing all the issues around the knock-on effects - people being left on the floor for 12 hours at a time and us not being able to live up to respond to the emergencies as we're trained to do."*[71]

In another roundtable we heard how ensuring access to local pharmacy services during normal working hours is not sufficient, and it was important to ensure access out-of-hours and at weekends as well. A stakeholder in this roundtable explained how a lack of access to their local pharmacy over the weekend had resulted in all their repeat prescriptions being re-routed to a large supermarket pharmacy further away without their permission. This resulted in significant delays to their treatment:

> *"[…] I recently went to an out-of-hours service and GP extended services, which was out of my usual locality. I needed a prescription for antibiotics, which was fine. I had to get that from my local supermarket instead of my local pharmacy. But then what happened was that because my pharmacy wasn't open during the weekend, then that knocked my regular repeat prescriptions off, and all my pharmacy started going to my local supermarket instead of my local pharmacy. And so, I then had to rearrange all my prescriptions again with my local pharmacist. And I wasn't aware, so I was like 3 weeks late for getting on medication. […] It's hard work, especially when you're caring for people. And I've got my own medical conditions. I have work and my mum, and you try your best to do the right thing and make sure you're managing your medications the best you can. So, it is really difficult when you have to fight the system a little bit."*[72]

In the same roundtable another stakeholder considered that this was a deliberate strategy some large pharmacies use to increase their dispensing volume and associated funding. They said this was stressful for patients and led to increased workload:

> *"We historically get lots of problems with this. As soon as you go to that pharmacy to get your medicine on a one-off occasion, they nominate you automatically as getting all your meds and it can be a target at times for them. I'm not saying that it is, some are better than others, but it's about the number of items that they dispense and the profitability of that community pharmacy. And I believe those pharmacies do have targets at times to try and*

71 Stakeholder roundtables
72 Stakeholder roundtables

> *hit and maintain that flow and the income, but they nominate automatically without the consent and awareness of the patients at the time. We are a dispensing practice, so we see a lot of rural patients that in out-of-hours have to go to a 100-hour pharmacy and then the next minute we lose them as dispensing patients because they've gone to a 100-hour pharmacy on a Sunday when they needed to get emergency medication and all their meds go there automatically. It causes confusion in the system and anxiety and stress for patients and staff that are trying to deal with those queries, and extra workload for all involved. And it all comes down to items dispensed."*[73]

The Department's submission does not explicitly reference how the commitment has received a positive impact for patients and people in receipt of social care but does point to decreased closure rates and improved access to pharmacy services in underserved areas.[74] NHS Bedfordshire, Luton and Milton Keynes ICB however explained that closure rates among PhAS-eligible and non-eligible pharmacies was not sufficient to evaluate the impact of the PhAS, outlining instead which data would help understand how well the PhAS was working to protect access:

> *"To truly assess the effectiveness of the PhAS, it would be beneficial to analyse data and studies that evaluate its impact on patient access to pharmaceutical services, pharmacy viability, and patient satisfaction in areas with fewer pharmacies. Additionally, gathering feedback from participating pharmacies, patients, and healthcare providers can provide valuable insights into the scheme's effectiveness and identify areas for improvement."*[75]

We have rated as 'requires improvement' the impact that the commitment has had on patients and people in receipt of social care due to the lack of data on patient outcomes available to us, or to ICBs and the wider public.

Was it an appropriate commitment? Rating: Requires improvement

There was criticism from several ICBs about the lack of targets or measures within the commitment to enable evaluation of the PhAS.[76] NHS Surrey Heartlands ICB said that the commitment was not appropriate because the new PhAS criteria had been put in place without any review as to whether the scheme had achieved the intended outcomes and objectives, and without any measures built into the commitment to assess the subsequent impact of changes to the criteria including whether they had beneficial or unintended consequences.[77] NHS Sussex Integrated Care similarly stated that the commitment does not include any measures to evaluate the consequences of the commitment to PhAS pharmacies, and the impact on the wider pharmacy network.[78]

NHS West Yorkshire ICB stated that it would be beneficial to adjust the eligibility criteria for the PhAS to include consideration of what they termed "wider access inequalities".[79]

73 Stakeholder roundtables
74 Department of Health and Social Care (APE0039)
75 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
76 NHS Surrey Heartlands ICB (APE0006), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Sussex Integrated Care (APE0037), NHS West Yorkshire ICB (APE0034)
77 NHS Surrey Heartlands ICB (APE0006)
78 NHS Sussex Integrated Care (APE0037)
79 NHS West Yorkshire ICB (APE0034)

While NHS Frimley Integrated Care said there was a need to maintain the PhAS to continue to protect access to local physical NHS pharmaceutical services, particularly for vulnerable or isolated populations, they called for the PhAS to be improved by increasing its transparency and consistency across different regions.[80] NHS Bedfordshire, Luton and Milton Keynes ICB stated the eligibility criteria should also consider the volume of additional services provided and the health needs of the local population in deprived and underserved areas.[81]

NHS Dorset Integrated Care and the distance selling pharmacy Pharmacy2U were generally positive about the need to support pharmacies in rural areas, but said that other financial support for community pharmacy is needed to prevent community pharmacy closures and improve access, including at weekends and out-of-hours.[82]

> *"[The PhAS] protects isolated and rural pharmacies, or those service populations on the edge of towns….it does not protect access on Saturdays or evenings and now many pharmacies have reduced hours to the contracted minimum, and the availability on weekends and evenings is even more sparse."*[83]

The RPS and the CCA both agreed financial difficulties faced by community pharmacy and closures meant the scheme is no longer fit for purpose.[84]

Humber LPC indicated that the best way to protect access to community pharmacy would be to revise the whole community pharmacy funding contract and increase the overall level of funding community pharmacies receive, and then, if necessary for some pharmacies, to provide more tailored support by adjusting the provisions that had been available previously under the Local Pharmaceutical Services (LPS) contract (the predecessor to the CPCF):

> *"The PhAS has helped some, but we think the best way to support the network is to have a properly funded pharmacy contract where contractors are not put in the situation where they are providing NHS activity at a loss, and that's currently allowed by the contract! If there are still contractors who need further support to maintain a network position in rural or other surroundings, that still require further assistance, perhaps revisiting the usage of Local pharmaceutical services (LPS) contracts may be more appropriate. The enhanced funding needed can be better understood, localised, and routed to them, but would also allow additional location, and need, specific services to also be delivered in these service deprived locations."*[85]

NHS Surrey Heartlands ICB[86] also implied that it would be better to drop the PhAS and instead reinstate provisions to protect access to small local pharmacies that had been part of the LPS.[87]

80 NHS Frimley Integrated Care (APE0020)
81 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
82 Pharmacy2U (APE0015), NHS Dorset Integrated Care (APE0027)
83 NHS Dorset Integrated Care (APE0027)
84 Royal Pharmaceutical Society (APE0038), The Company Chemists' Association (APE0018), The Community Pharmacy Humber LPC (APE0032)
85 The Community Pharmacy Humber LPC (APE0032)
86 NHS Surrey Heartlands ICB (APE0006)
87 Pharmaceutical Services Negotiating Committee, "Essential Small Pharmacies - Archive information", accessed 190623

The Department's submission does not explicitly include a reference to why the Department thinks this is an appropriate commitment but mentions decreased closure rates for pharmacies on the scheme and increased access for those in need of pharmacy services.[88]

We rated the appropriateness of the commitment as 'requires improvement' due to the concerns we heard from many stakeholders that the commitment is too narrow in scope to address the major funding challenges faced by community pharmacy providers which are leading to closures. So whilst the commitment, as written, which is to maintain the PhAS, has been met, the commitment is unlikely to be sufficient to fully protect access to local pharmaceutical services in areas with fewer pharmacies.

Commitment 2: Review the funding model for community pharmacy

Overall Commitment Rating and Overview of review the funding model for community pharmacy. Rating: Requires improvement

This commitment is to review of the funding model for community pharmacy, in particular the balance between funding for dispensing and for delivering services. The commitment came under the heading of Guaranteeing Investment in the year 1 CPCF (2019–2014). According to the CPCF year 1, new technology and transformation will reduce the costs of dispensing over the course of the five-year settlement, and savings made will be used to fund further community pharmacy service provision.[89]

The Department acknowledged that the dispensing efficiencies anticipated in year 1 of the CPCF (2019–2014) have not been realised as anticipated. Year 3 of the CPCF published in August 2021 stated that:

> *"… the pandemic has delayed and disrupted plans for service introduction and planned legislative changes that would support pharmacies in making further dispensing efficiencies."*[90]

The Covid-19 pandemic also placed additional demands on the community pharmacy sector,[91] which provided additional services such as Covid-19 vaccinations and delivery of medication of the homes of vulnerable patients who were shielding.[92] Year 3 of the CPCF provided an extra year of transitional payment to be used to:

- support engagement with the local PCN and ICS, to further integrate services and increase the uptake of clinical services;
- increase the digital maturity of their organisations to, for example, reduce the reliance on paper in dispensing workflows, communicate digitally with patients around prescription collections, and increase the availability of telephone or video consultations for clinical services;

88 Department of Health and Social Care (APE0039)
89 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24, July 2019
90 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021
91 Ian Maidment et al "Rapid realist review of the role of community pharmacy in the public health response to COVID-19" BMJ Open, Vol 11, e050043 (2021).
92 House of Commons Library Research Briefing, Pharmacy and the impact of Covid-19, March 2021

- make dispensing efficiencies and prepare for a more service-based roles by reviewing their business processes. This could include consideration of, for example, efficient skill mix, automated dispensing systems, planning and predicting workload and engaging on hub and spoke changes.[93]

Overall, our rating of this commitment is that it 'requires improvement'. This rating is based on stakeholders agreeing that there is a need to review the funding model, and in particular to review the quantum of funding in relation to demand, now and in the future, but that such a review has not occurred. Furthermore, although we received little evidence about the impact of the commitment on patients and people in receipt of social care, we did receive evidence about the - mostly negative - impact that the current funding model is having on providers and on patients and people in receipt of social care. We consider this to be evidence of the impact that *not* meeting the commitment is having on patients and people in receipt of social care, and therefore include it within our evaluation. We did not receive any evidence indicating that a lack of funding or resource was the reason that the commitment has not been met.

Was the commitment met overall (or on track)? Rating: inadequate

In their submission to us, the Department stated that the commitment had been met in full, stating that "The funding model is under constant joint review with DHSC, NHSE and PSNC" with "fees adjusted as required depending on the forecasted levels of service uptake and prescription items".[94]

Despite this, most of the stakeholders we heard from did not consider the funding model to have been reviewed appropriately, arguing that a more fundamental review was needed.[95] The PSNC were clear in their submission that, in their opinion, there had been no appropriate review:

> *"[…] we do not consider the [negotiated 5 year CPCF agreement] to have been an appropriate review of the funding model."*[96]

They went on to say that a complete overhaul of the funding model was required, to recognise the different approach that was required for community pharmacy compared to other health sectors:

> *"Incentives need to be embedded that drive the desired behaviours, funding capacity (contractors being available), activity and also providing a share of the benefits of good performance by contractors."*[97]

93 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021

94 Department of Health and Social Care (APE0039)

95 Care England (APE0019), NHS Surrey Heartlands ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Greater Manchester Integrated Care (APE0016), NHS Frimley Integrated Care (APE0020), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Sussex Integrated Care (APE0037), Avon LPC (APE0017), Community Pharmacy Lincolnshire (APE0022), Pharmaceutical Services Negotiating Committee (APE0009), British Oncology Pharmacy Association (APE0021), The Pharmacists' Defence Association (APE0030), Royal Pharmaceutical Society (APE0038), Pharmacy2U (APE0015), The Company Chemists' Association (APE0018), National Pharmacy Association (APE0026), Community Pharmacy Suffolk LPC (APE0029), The NPA Women Members' Forum (APE0031), The Community Pharmacy Humber LPC (APE0032), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

96 Pharmaceutical Services Negotiating Committee (APE0009)

97 Pharmaceutical Services Negotiating Committee (APE0009)

Trade association the NPA described the funding model as "fundamentally broken"[98] and Humber LPC concluded that the funding model was "broken beyond repair".[99] Several stakeholders told us that insufficient funding had led to pharmacies closing or reducing their hours.[100]

Major criticisms from stakeholders were that the global sum for community pharmacy was fixed for 5 years in 2019, pre-pandemic, and that a review was needed to take into account the increases in costs and pressures community pharmacies are experiencing due to increased dispensing and service provision, inflation and significant workforce issues.[101] For example, the National Pharmacy Association (NPA) stated:

> *"An initial cut to funding; a flat 5 year fixed financial resource level; then Covid pressures; increasing demands; roll out of our new enhanced clinical service role without adequate support for infrastructure and implementation; a workforce crisis; and inflation have left the profession and contractor network severely stretched."*[102]

Many stakeholders stated that the CPCF global sum agreed in 2019 and then fixed for five years was insufficient to cover the costs of dispensing and service provision which had risen over the period. NHS Surrey Heartlands ICB stated that this had led to what they termed "an increase in workload for a lower payment per activity level…compounded by inflationary and workforce pressures".[103] NHS Sussex Integrated Care also indicated that the public "…had relied on the access maintained by community pharmacy" during the Covid-19 pandemic and yet the funding model had not been revised to account for this. They concluded that "The NHS benefits from high levels of unfunded activity by community pharmacy."[104] Care England also told us that the current funding model makes it costly for pharmacies to provide same-day medication to care homes free of charge.[105]

Several stakeholders pointed out that the current CPCF funding model is predicated on planned dispensing efficiencies delivered via workforce and regulatory reforms, which have not occurred.[106] This was explained by a stakeholder in our roundtable discussions:

98 National Pharmacy Association (APE0026)

99 The Community Pharmacy Humber LPC (APE0032)

100 NHS Coventry and Warwickshire ICB (APE0025), NHS Sussex Integrated Care (APE0037), NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), Community Pharmacy Lincolnshire (APE0022), Community Pharmacy Suffolk LPC (APE0029), Professor Ian Maidment, Aston University (APE0004), Care England (APE0019), NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027), British Oncology Pharmacy Association (APE0021)

101 NHS Surrey Heartlands ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Greater Manchester Integrated Care (APE0016), Care England (APE0019), British Oncology Pharmacy Association (APE0021), NHS Northamptonshire ICB (APE0023), National Pharmacy Association (APE0026), NHS Dorset Integrated Care (APE0027), NHS Sussex Integrated Care (APE0037), Dr Ali Hindi, University of Manchester (APE0001), NHS Suffolk and North East Essex ICB (APE0010) , NHS Black Country ICB (APE0014), The Company Chemists' Association (APE0018), British Oncology Pharmacy Association (APE0021), Community Pharmacy Lincolnshire (APE0022), The Community Pharmacy Humber LPC (APE0032), NHS Leicester, Leicestershire and Rutland ICB (APE0033), Royal Pharmaceutical Society (APE0038), NHS Coventry and Warwickshire ICB (APE0025)

102 National Pharmacy Association (APE0026)

103 NHS Surrey Heartlands ICB (APE0006)

104 NHS Sussex Integrated Care (APE0037)

105 Care England (APE0019)

106 Community Pharmacy Suffolk LPC (APE0029), Pharmacy2U (APE0015), National Pharmacy Association (APE0026), NHS Dorset Integrated Care (APE0027), The Company Chemists' Association (APE0018)

> *"The 2019 agreement was predicated on certain efficiencies being delivered by the government, none of which have occurred. There was talk of hub and spoke, so the ability to dispense medicines across legal entities. That hasn't happened. There was talk about updating the laws which predate the NHS, which govern the supervision of pharmacists and what they can supervise. That hasn't happened."*[107]

According to NHS Dorset ICB and the CCA, the lack of reform has led to community pharmacies having a shortfall of funds for dispensing or operating at a loss. This has been compounded by the impacts of Covid-19 and inflation, which also have not been taken into account in the funding model.[108] NHS Bedfordshire, Luton and Milton Keynes ICB similarly explained how a funding model in which clinical services are paid out of the same global sum as dispensing, has resulted in a lack of funds for both. This lack of funding has been exacerbated by increases in the cost of living, decline in high street footfall, difficulties recruiting and retaining staff, and lack of access to and funding for improvements to digital systems and pharmacy premises. They concluded that the impact of these funding pressures was that pharmacies are not offering advanced services:

> *"Contractors may choose not to offer these advanced services as they require a huge investment in work, in return for little remuneration or because they simply do not have the right staff (or skill mix)."*[109]

NHS Leicester, Leicestershire and Rutland ICB stated that the shortfall in funding for dispensing could lead to patients not being able to receive the medication they need:

> *"…as payments for services increase, reimbursement for dispensing reduces. There is anecdotal information that a number of community pharmacies are now dispensing at a loss and may not always obtain the medicines a patient needs because of this and that some independent pharmacists are not always able to pay themselves a salary each month."*[110]

Another common criticism of the current funding model is that it relies on community pharmacies receiving referrals from other parts of the NHS (such as general practice and hospitals) in order to be paid for some of the essential and extended services they deliver. Engagement from those external agencies—and therefore the funding community pharmacies receive for them—is patchy and unreliable.[111] NHS Nottingham and Nottinghamshire ICB, NHS Dorset Integrated Care, and NHS Leicester, Leicestershire and Rutland ICB all indicated that this was a problem for pharmacies providing smoking cessation services, as well as the CPCS and the DMS (both covered in Chapter 2 of this report).[112] Avon LPC stated that, despite the significant amount of work and funding they had put into the CPCS, including funding digital referral mechanisms and an implementation manager, they were not getting referrals from some providers.[113] NHS

107 Stakeholder roundtables
108 NHS Dorset Integrated Care (APE0027)
109 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
110 NHS Leicester, Leicestershire and Rutland ICB (APE0033)
111 NHS Nottingham and Nottinghamshire ICB (APE0013), Avon LPC (APE0017), Community Pharmacy Lincolnshire (APE0022), Community Pharmacy Suffolk LPC (APE0029), NHS Leicester, Leicestershire and Rutland ICB (APE0033), Anonymised (APE0007), NHS Dorset Integrated Care (APE0027)
112 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Dorset Integrated Care (APE0027)
113 Avon LPC (APE0017)

Nottingham and Nottinghamshire ICB described how a lack of referrals did not just result in a lack of funding and availability of the services, but also led to community pharmacies losing confidence to deliver the services:

> *"[…] there has not been a single reported referral to the smoking cessation service to pharmacies signed up for this advanced service in the NHS Nottingham and Nottinghamshire ICB area. The smoking cessation advanced service may be affected by the local commissioned service, so availability of the Community Pharmacy service is not widely known....lack of referrals reduces their confidence to deliver the services due to the time delay between delivery and training."*[114]

Several stakeholders explained that workforce costs and shortages have increased since 2019 and this is not considered within the funding model. Dr Ali Hindi of the University of Manchester stated that the remuneration community pharmacies receive to provide new clinical services "appears to be insufficient to make up for additional investment of staff/resources" that delivery of these services requires.[115] Avon LPC indicated that additional funding was required to free up pharmacy teams to deliver services, but referrals from other services made it difficult to plan workload so it was not cost effective to employ additional staff to deliver them.[116] NHS Coventry and Warwickshire ICB stated that workforce shortages were exacerbated by pharmacist recruitment into PCNs, and that the rise in costs of hiring locum staff putting financial pressure on pharmacies, and limiting their ability to deliver more services.[117] NHS Surrey Heartlands ICB[118] and NHS Sussex Integrated Care[119] also indicated that workforce pressures had been caused by pharmacists and technicians moving out of community pharmacy into primary care funded by the NHSE Additional Roles Reimbursement Scheme (AARS).[120]

The Department's submission partly acknowledged these issues, setting out that:

> *"[…] concerns have been expressed by the PSNC and others that the CPCF funding is not enough. For 2022/23 and 2023/24 an additional £100 million was secured. Additionally, on the 9th May 2023 a further investment of up to £645 million, over 2023/24 and 2024/25 was announced as part of the Delivery plan for recovering access to primary care to support pharmacies in delivering more services."*[121]

We do not consider that this additional funding amounts to the review of the funding model and the balance between spend on dispensing and new services that was promised in the commitment.

114 NHS Nottingham and Nottinghamshire ICB (APE0013)
115 Dr Ali Hindi, University of Manchester (APE0001)
116 Avon LPC (APE0017)
117 NHS Coventry and Warwickshire ICB (APE0025)
118 NHS Surrey Heartlands ICB (APE0006)
119 NHS Sussex Integrated Care (APE0037)
120 NHS England "Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance", accessed 200623
121 Department of Health and Social Care (APE0039)

Many stakeholders told us that they wanted a revised community pharmacy funding model to maintain the increased focus on service delivery but in a way that did not compromise dispensing, and that was evidence-based.[122] Others went further in describing the need for a more wide-ranging review, based on research evidence, covering capacity-building within community pharmacy, integration with primary care, and better use of pharmacy professionals' skills.[123]

Overall we conclude that the promised robust review has not occurred, the commitment has not been met and therefore we have rated this aspect of the commitment as 'inadequate'.

Was the commitment effectively funded (or resourced)? Rating: Good

In rating this aspect of the commitment, we consider whether there is enough funding or resourcing to enable a review of the funding model, not whether the quantum of funding agreed for the CPCF is sufficient. Aspects of the latter is covered in our evaluation of the first commitment within the area of Community Pharmacy, both commitments in the area of Integrated Care (including patient safety) and the commitment in the area of Extended Services.

We rate the funding and resourcing of this commitment as 'requires improvement' because we received no evidence to indicate whether the level of funding and resource to achieve the commitment is sufficient or insufficient.

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Requires improvement

In this section we consider the impact of the commitment to review the funding model on patients and people in receipt of social care. The Department's submission does not explicitly outline how this commitment has impacted on patients and people in receipt of social care.[124] NHS Bedfordshire, Luton and Milton Keynes ICB indicated a lack of standardised metrics to collect data on patient experience and outcomes in addition to data on activity levels. They stated these data were vital to inform commissioning and to raise the profile of the benefits community pharmacy brings to the population:

> *"Achieving a positive impact necessitates measuring activity (renumerated via payments) but we need to consider outcomes and experience. To demonstrate the benefits, we need to be able to articulate and evidence the impact of these services to commissioners, partners and the public. We urgently need some standard outcome metrics rather than relying on activity levels."*[125]

122 Dr Ali Hindi, University of Manchester (APE0001), Care England (APE0019), NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Greater Manchester Integrated Care (APE0016), NHS Frimley Integrated Care (APE0020), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Sussex Integrated Care (APE0037), The Company Chemists' Association (APE0018), The Pharmacists' Defence Association (APE0030), Royal Pharmaceutical Society (APE0038), Pharmacy2U (APE0015), Community Pharmacy Lincolnshire (APE0022), National Pharmacy Association (APE0026)

123 NHS Suffolk and North East Essex ICB (APE0010), The NPA Women Members' Forum (APE0031), The Pharmacists' Defence Association (APE0030), The Company Chemists' Association (APE0018)

124 Department of Health and Social Care (APE0039)

125 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

As explained above, we judge that the funding model has not been reviewed as promised in the commitment. Therefore our rating takes into account the evidence we received about the impact on patients and people in receipt of social care of the delivery of community pharmacy under the current—unreviewed—funding model.

In their submissions, several ICBs and the RPS indicated that patients did benefit from community pharmacies delivering additional services, when this was possible. However, they indicated that delivery could be patchy, potentially leading to inequalities in benefit to patients and people in receipt of social care.[126] NHS Sussex Integrated Care quoted figures from the PSNC Pharmacy Pressures Survey 2023:[127]

> *"(52%) of pharmacy staff report that the pharmacies they work in were unable to provide advanced services for patients and 44% reported being unable to provide locally commissioned services to patients due to workforce and financial pressures….it is inevitable that the variation in uptake of the new services will create additional inequalities for patient access to those services."*[128]

In their submission, the RPS stated that some pharmacies had chosen not to deliver some services (such as contraceptive services) due to what they called "the perverse incentives within the contractual framework". They characterised the inconsistent delivery of pharmacy services across the country as a "postcode lottery". The RPS additionally indicated that the general practice and community pharmacy contracts promote competition rather than collaboration between professionals, with negative consequences for service delivery for local communities.[129] Related to this, several stakeholders described how patients were negatively impacted when a lack of funding meant that pharmacies were disincentivised from delivering services, or when pharmacies were unable to deliver services due to workforce issues, IT problems, and lack of referrals from other parts of the health service.[130]

According to Dr Ali Hindi of the University of Manchester, while there is evidence of patients benefiting from some services (such as minor ailments, weight management and smoking cessation) the evidence around patient benefit is typically based on the number of patients who take up a service rather than the quality of the service.[131] Two ICBs (NHS Nottingham and Nottinghamshire ICB and NHS Leicester, Leicestershire and Rutland ICB) stated that they were unable to provide information on patient benefit from advanced services since data is held centrally rather than at ICS level.[132]

126 NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038)

127 PSNC, PSNC Briefing 009/23: Summary of the results of PSNC's 2023 Pharmacy Pressures Survey, April 2023
Note: This survey was launched in January 2023 and captured data from "over 900" pharmacy owners representing "more than 6,200 pharmacy premises" and "more than pharmacy team members"

128 NHS Sussex Integrated Care (APE0037)

129 Royal Pharmaceutical Society (APE0038)

130 Anonymised (APE0007), NHS Suffolk and North East Essex ICB (APE0010), NHS Black Country ICB (APE0014), Pharmacy2U (APE0015), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), Community Pharmacy Suffolk LPC (APE0029), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038), British Oncology Pharmacy Association (APE0021), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

131 Dr Ali Hindi, University of Manchester (APE0001)

132 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Leicester, Leicestershire and Rutland ICB (APE0033),

As stated above, several stakeholders told us that lack of funding had led to pharmacies closing or reducing their hours.[133] NHS Surrey Heartlands ICB, NHS Suffolk and North East Essex ICB and Suffolk LPC indicated that this was a particular problem in deprived areas.[134] The British Oncology Pharmacy Association indicated that patients with cancer were adversely affected by closures due to funding shortages:

> *"The lack of community pharmacy funding and the resulting closure of community pharmacies is very concerning and will significantly restrict the ability to utilise and further expand these services, including those that would directly benefit cancer patients."*[135]

The impact of closures on patients and the health service more widely was also discussed by participants in our stakeholder roundtables:

> *"The reality is though, as I've said, since 2015 funding for pharmacy from this government has been cut in real terms by 30% and workload has been increased by 36%, so do the maths. Pharmacies are really struggling. Nobody has that kind of margin that they can absorb and continue to operate. And so that's why we're seeing closures."*[136]

Another roundtable participant stated:

> *"Of course, the NHS and primary care is very much "Have you chatted with your pharmacist? Have you been to your community pharmacy to help the GPs and help reduce hospital admissions?" Where of course all these community pharmacies are closing, so there's even more pressure being put on maybe the one you've got in the village or the one you've got in the town centre, because everyone's piling into this community pharmacy to try and help the GPs try and help the hospitals. But of course they're all closing, so it's putting more and more pressure on to these single pharmacies. And taking into account staffing and all the services they've been asked to put on as well, I think has quite a big impact on them."*[137]

The evidence provided to us indicates that many are not benefiting from the current funding model, which we consider has not been reviewed as promised. We have therefore rated this aspect of the commitment as 'requires improvement'.

133 NHS Coventry and Warwickshire ICB (APE0025), NHS Sussex Integrated Care (APE0037), NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), Community Pharmacy Lincolnshire (APE0022), Community Pharmacy Suffolk LPC (APE0029), Professor Ian Maidment, Aston University (APE0004), Care England (APE0019), NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027), British Oncology Pharmacy Association (APE0021),

134 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Sussex Integrated Care (APE0037), Community Pharmacy Suffolk LPC (APE0029)

135 British Oncology Pharmacy Association (APE0021)

136 Stakeholder roundtables

137 Stakeholder roundtables

Was it an appropriate commitment? Rating: Good

Most stakeholders agreed that the funding model needs review, for the reasons described within this chapter.[138]

The PSNC, who together with NHSE and the Department negotiated the current CPCF, stated that the Government's recent commitment to an independent economic review of the funding model was a welcome step that could be very helpful, "if completed appropriately".[139] The Department's submission did not mention an independent review.[140]

We rated the appropriateness of the commitment as 'good' because of the widespread agreement among stakeholders that a review of the funding model is required, despite it not having been delivered.

138 Care England (APE0019), NHS Surrey Heartlands ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Greater Manchester Integrated Care (APE0016), NHS Frimley Integrated Care (APE0020), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Sussex Integrated Care (APE0037), Avon LPC (APE0017), Community Pharmacy Lincolnshire (APE0022), Pharmaceutical Services Negotiating Committee (APE0009), British Oncology Pharmacy Association (APE0021), The Pharmacists' Defence Association (APE0030), Royal Pharmaceutical Society (APE0038), Pharmacy2U (APE0015), The Company Chemists' Association (APE0018), National Pharmacy Association (APE0026), Community Pharmacy Suffolk LPC (APE0029), The NPA Women Members' Forum (APE0031), The Community Pharmacy Humber LPC (APE0032), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

139 Pharmaceutical Services Negotiating Committee (APE0009)

140 Department of Health and Social Care (APE0039)

2 Integrated care (including patient safety)

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E.	Good	Requires improvement	Good	Good	Good
Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service').	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

In this section we provide an assessment of Government commitments in relation to the integration of pharmacy services, including patient safety. Two commitments were selected for evaluation:

"Deliver a new Community Pharmacist Consultation Service with referrals from NHS 111, GPs and A&E."

"Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicines Service')."

Both commitments in this policy area aim to achieve greater integration of community pharmacy with other parts of the NHS and improve medicines safety.

The first commitment was introduced in Year 1 of the CPCF. The CPCS is an advanced service which community pharmacies can opt to deliver under the contract.[141]

141 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)

The second commitment was introduced in Year 3 of the CPCF. The DMS is an Essential service which community pharmacies must deliver under the contract.[142]

Commitment 1: Community Pharmacy Consultation Service

Overall Commitment Rating and Overview of the Community Pharmacy Consultation Service: Good

This commitment sets out the plan to deliver the CPCS. Under the CPCS, patients can be referred to from NHS 111, GP or from an UEC setting[143] to a community pharmacy for a same-day appointment (face-to-face or remotely) to receive care for minor illnesses and/or to receive their regular medicine urgently. Pharmacies can then refer patients onwards (or back) as necessary.[144]

The commitment was included under the heading Urgent Care in Year 1 of the five-year CPCF (2019–2024), published in July 2019. The framework set out the aims of the CPCS as to relieve pressure on the wider NHS and contribute to the system being better placed to manage winter pressures, and stated that the CPCS would be further developed over the five-year funding period.[145] The CPCS was launched in October 2019 with referrals from NHS 111. Referrals from GP were rolled-out in November 2020[146] (slightly later than originally planned April 2020[147]). Referral pathways from UEC followed in 2023.[148]

NHS England describes the purpose of the CPCS as alleviating pressure on GP practices and emergency departments, making best use of the knowledge and skills of pharmacists, improving access to services and providing more convenient care close to patients' homes.[149] In April 2020 NHS England indicated that the ambition is for the CPCS to contribute to community pharmacy reducing the number of GP appointments by 6%, a total of 20.4 million appointments:

> *"Patients and the general public access community pharmacies for self-care advice and to purchase over the counter medicines. It is however difficult sometimes for patients to know when it might be more appropriate to access GP advice. It is estimated that 6% of all GP consultations could be safely transferred to a community pharmacy (20.4 million appointments per year) and there is good evidence that the advice provided by community pharmacists as part of a consultation about symptoms of minor illness will result in the same outcome as if the patient went to see their GP or attended an Emergency Department."*[150]

142 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022) (August 2021)

143 Note: UEC settings include Emergency Departments, Urgent Treatment Centres and Accident and Emergency Departments.
NHSBSA, Urgent and Emergency Care (UEC) referrals to NHS Community Pharmacist Consultation Service (CPCS) pilot | NHSBSA, accessed 220623

144 NHS England, NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care, accessed 080623

145 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)

146 NHS England, NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care, accessed 080623

147 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)

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

149 NHS England, NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care, accessed 080623

150 NHS England, Service Level Agreement and Service Specification for the General Practice Community Pharmacist Consultation Service (GP CPCS) (April 2020

The CPCS is an Advanced Service which means pharmacies can choose whether to provide it.[151] The CPCF (2019–2024) states that community pharmacy received transitional financial support in Year 1 of the CPCF (2019/20) to implement the CPCS, followed by a payment of £14 per completed consultation. The CPCF (2019–2024) states that the payment model would be reviewed at the end of 2020/21 informed by evaluation of the CPCS.[152] In 2023, referrals were paid at the £14 fee.[153]

PCNs (which include GP practices) and UEC providers are not required to implement the CPCS, however PCNs receive payments for GP CPCS referrals via the Impact Investment Fund (the IIF), which is designed to incentivise them to provide the service. The IIF implementation guidance published in September 2022 provides information about the number of CPCS referrals expected from PCNs, which they say is set at a "modest level" aimed at demonstrating the PCN is able to make referrals via a functioning referral pathway:

> *"The activity level called for by this indicator has been set at a minimal level, as its purpose is to demonstrate that practices in the PCN have a functioning referral pathway to community pharmacy under the CPCS. As such, this IIF indicator is based on a single activity threshold for CPCS referrals – this threshold has been set at a modest level, corresponding to 0.65 CPCS referrals per 1000 registered patients per week."*[154]

We have given an overall rating for this commitment of 'good'. Our rating is based on the service being successfully rolled out, with reports of positive impacts on patients despite patchy provision due to reported issues such as a lack of trained workforce and IT issues. From the evidence we received, the CPCS is widely seen as enabling community pharmacy to support more people with minor conditions and freeing up capacity within other parts of the health service to manage more complex conditions. The Department referred to an evaluation of a pilot of the UEC CPCS in their submission,[155] however we did not find evidence of any national independent evaluation of the CPCS. This prevented us from evaluating how well the scheme is enabling community pharmacy to relieve pressure on other parts of the health system.

Was the commitment met overall (or on track)? Rating: Good

The Department stated this commitment has been met in full. They report that since the service started in November 2019, over 2 million referrals have been made to CPCS, with a split of about 80% from NHS 111 and around 20% from GP. UEC referrals started 15 May 2023.[156]

The CCA described the CPCS as "considerably underused", citing national figures from 2021/22 which indicated 700,000 payments for consultations were received by community pharmacy, equivalent to around one consultation per pharmacy per week, and mostly

151 NHS Business Services Authority Community pharmacy advanced service specification: NHS Community Pharmacist Consultation Service, (May 2023)
152 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)
153 NHS England, Community pharmacy advanced service specification: NHS Community Pharmacist Consultation Service, accessed 220623
154 NHS England, Network Contract Directed Enhanced Service Investment and Impact Fund 2022/23: Updated Guidance (September 2022)
155 Department of Health and Social Care (APE0039)
156 Department of Health and Social Care (APE0039)

from NHS 111 not GP.[157] There was also criticism from a number of stakeholders that, although the CPCS had set start dates, it had no set dates for implementation.[158] However, the evidence we received confirmed that CPCS referral pathways from NHS 111 are well established, that GP pathways are in place, and UEC referrals started in May 2023, slightly delayed from the planned start date of March 2023.[159]

The PSNC indicated the delay in implementing UEC pathways was due to the impact of Covid-19 on hospital trusts and urgent care providers.[160] At the time of submitting evidence to us, several ICBs or LPSs had not yet started UEC referrals.[161] Community Pharmacy Suffolk (Suffolk LPC) told us that, although they considered being part of the UEC CPCS pilot locally, they decided against it because they struggled to provide evidence to the major stakeholders in the system that the CPCS would be beneficial:

> *"[…] there was no appetite for this from the system. The reasons for this were that the IT was an issue, the patient pathway introduced a number of risks that were deemed unacceptable, and it did not seem to deliver significant value to patients or the system over what was currently available. It is the huge barrier to all these service strands being successful. The provider pays model has increased the cost of these services to contractors and fragmented data collection meaning that it is difficult to evidence the value of these services to the systems and service users."*[162]

Other ICBs and LPSs reported pilots of referrals from UEC, with varied success.[163] For example, NHS Northamptonshire ICB indicated that two Acute trusts within their ICB had been engaged with the CPCS, testing was complete, and they were awaiting an imminent go-live date from the team. However in another hospital in the ICB, the CPCS had gone live and failed, so A&E teams were "remobilizing it cautiously" with engagement from two community pharmacies and an LPC.[164]

It was clear from the submissions we received that although NHS 111 referral pathway was fairly well embedded, the GP referral pathway was less well embedded, with some stakeholders characterising it as patchy.[165] Some ICBs told us that patchiness of the GP and UEC CPCS service delivery was because GPs and UEC providers did not have to sign up to the CPCS, and even for those that did sign up, a lack of local referral targets resulted in variability.[166] For example, NHS North East London ICB stated that there

157 The Company Chemists' Association (APE0018)

158 Royal Pharmaceutical Society (APE0038) NHS Gloucestershire ICB (APE0002), NHS Surrey Heartlands ICB (APE0006), NHS North East London ICB (APE0024)

159 Anonymised (APE0007), NHS Coventry and Warwickshire ICB (APE0025), NHS West Yorkshire ICB (APE0034), Avon LPC (APE0017), Community Pharmacy Suffolk LPC (APE0029)

160 Pharmaceutical Services Negotiating Committee (APE0009)

161 NHS Gloucestershire ICB (APE0002), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS North East London ICB (APE0024), Community Pharmacy Suffolk LPC (APE0029)

162 Community Pharmacy Suffolk LPC (APE0029)

163 NHS Northamptonshire ICB (APE0023), NHS Coventry and Warwickshire ICB (APE0025), Avon LPC (APE0017), NHS West Yorkshire ICB (APE0034)

164 NHS Northamptonshire ICB (APE0023)

165 NHS Gloucestershire ICB (APE0002), Anonymised (APE0007), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), NHS Frimley Integrated Care (APE0020), NHS North East London ICB (APE0024), NHS Northamptonshire ICB (APE0023), NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), The Company Chemists' Association (APE0018)

166 NHS Surrey Heartlands ICB (APE0006), NHS Dorset Integrated Care (APE0027), NHS West Yorkshire ICB (APE0034), NHS North East London ICB (APE0024)

was a "wide range in activity from a single referral up to hundreds per month by the most active GP practices."[167] The NPA indicated that their members receive few GP CPCS referrals and they questioned the impact the service was having on reducing pressure on general practice:

> *"A successful outcome would be a reduction on the current 20 million minor illness GP appointments, however, NPA members inform us that they receive low to no referrals through the GPCPCS per week."*[168]

In their follow-up submission to us, the Department stated that although there was a "spike in referrals from GPs linked to the launch of the IIF", by May 2023 just under 12% of PCNs had reached the target CPCS referral rate (which, as indicated above, was set at a "modest level" of 0.65 CPCS referrals per 1000 registered patients per week):

> *"Data sourced from Calculating Quality Reporting Service in early May 2023 showed 11.9% of PCNs reached the 2022/23 IIF target CPCS referral rate (ACC-09), although this shows achievement prior to any revisions agreed by PCNs and commissioners – which potentially could have a significant impact on the achievement that ultimately determines payment."*[169]

The Department also cited variable ICB engagement with the IIF as contributing to variability in GP CPCS implementation, implying that there was lower uptake of the GP CPCS in rural areas where patients were already served by community pharmacies and where GPs dispensed medicines (dispensing doctors).[170]

IT issues were identified by several stakeholders as a major barrier to the GP pathway in particular, although there were also reports of IT problems with NHS 111 referrals.[171] NHS North East London ICB described how IT issues had delayed the start of the GP CPCS in their ICS by two and a half years:

> *"By not having an integrated IT system in place GP CPCS had an extremely delayed start (meant to launch Nov 2020 and after a very small number of referrals it was 1.3.23 before it really took off in the way that we feel it should have."*[172]

NHS Suffolk and North East Essex ICB described similar IT challenges with the GP CPCS:

> *"GP CPCS has been less successful nationally and locally, with only small pockets of practices utilising the service in significant numbers. The referral process is not well integrated into general practice operations/software and the lack of integration with community pharmacy operations and IT is mirrored."*[173]

167 NHS North East London ICB (APE0024)
168 National Pharmacy Association (APE0026)
169 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
170 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
171 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS North East London ICB (APE0024), National Pharmacy Association (APE0026), Community Pharmacy Suffolk LPC (APE0029), The Community Pharmacy Humber LPC (APE0032), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
172 NHS North East London ICB (APE0024)
173 NHS Suffolk and North East Essex ICB (APE0010)

NHS Black Country ICB also said that "long-winded electronic referral systems" hampered uptake of the GP CPCS among GP surgeries.[174] NHS Northamptonshire ICB explained that GP practices with low referral rates bypass the "cumbersome" digital referral service by asking patients to attend the pharmacy. This implies pharmacies will not be able to claim for the referral.[175]

In their follow-up response, the Department indicated that CPCS referrals could be made by "a variety of electronic referral routes" including NHS mail[176] as well as other systems and that they recognised that difficulties with some of these systems hindered referral pathways being established, especially in UEC settings but also in GP:

> *"Where the referral requires minimal input from the referring teams the CPCS is adopted well. Where there are complexities (such as manual data transfer, separate referral/ assessment tools), the referral pathway has been harder to establish (in UEC settings particularly and some GP settings)."*[177]

Other challenges to the GP CPCS were related to workforce. NHS Black Country ICB stated that although 162/181 GP practices in their ICS had agreed to implement GP CPCS, only 110 were actively engaged. As well as challenges staff had using referral systems, as described above, the lack of engagement was due to a lack of understanding among GP staff about the benefits of the CPCS which meant they did not use it. NHS Black Country ICB also described a lack of knowledge among GP staff about which referrals are appropriate, which resulted in pharmacies sending back referrals and losing trust in the system.[178] NHS Leicester, Leicestershire and Rutland ICB[179] and NHS Gloucestershire ICB reported similar problems:

> *"GP practices struggle to understand how significant the benefit might be to them. They are also wary that Community Pharmacists will not have the time or ability to deliver. Therefore, they worry that referrals will be bounced back"*[180]

Several ICBs explained that some of these difficulties could be overcome by GP surgeries having a good relationship with the local pharmacies. This enables GP staff to understand the scope of the pharmacist's role, reduces inappropriate referrals, and improves communication when patients need to be referred back to the GP.[181] Lack of confidence among staff making referrals was however not unique to the GP CPCS. Stakeholders also reported training needs within NHS 111 and UEC providers to increase their confidence in referring to community pharmacy.[182]

In their follow-up response, the Department recognised that clinician and patient confidence is "key to the service's success" and variability in this confidence contributes

174 NHS Black Country ICB (APE0014)
175 NHS Northamptonshire ICB (APE0023)
176 NHS England, "NHSmail" accessed 220623.
Note: NHS mail is a secure email service approved by the Department of Health and Social Care for sharing patient identifiable and sensitive information.
177 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
178 NHS Black Country ICB (APE0014)
179 NHS Leicester, Leicestershire and Rutland ICB (APE0033)
180 NHS Gloucestershire ICB (APE0002)
181 NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014)
182 Anonymised (APE0007), Avon LPC (APE0017)

to the variability in CPCS implementation. They confirmed reports from stakeholders that clinicians who are experienced at working with community pharmacies have more confidence in referring patients via GP and UEC referral pathways, and stated that an external company had been commissioned to support GP practices to increase referrals in NHS Regions with less maturity with implementing CPCS. Around two thirds of the 1151 practices contacted had engaged with this support, which comprised 3 introductory webinars with 229 participants in total and 66 training sessions with 1097 participants in total. The Department reported that "as of April 2023, over 92% of practices were reported by regions to be engaged or ready to refer", however as stated above, the Department also indicated that only 11.9% PCNs had reached the IIF CPCS referral target by May 2023.[183]

The Department also indicated that lack of patient confidence in the service had limited referrals to community pharmacy, particularly from UEC settings. They indicated that referrals to the CPCS for sore throats and hoarse voices had been suspended in April/May 2020 to limit the number of patients sent to community pharmacies at the start of the pandemic, and this led to a decline in referrals until May/June 2021 when referrals recommenced. They went on to say that this suspension had led to a lag in the service recovering which was "driven by patient confidence". In response, they have developed and rolled out e-learning for NHS 111 and 999 service providers to improve patient understanding about the CPCS and encourage uptake.[184]

High workloads and high staff turnover in general were also identified by stakeholders as part of the cause of the lack of engagement with the CPCS.[185] NHS Black Country ICB said that workload in community pharmacy was an issue:

> *"In community pharmacy, as with other services, there have been workforce issues e.g., locums not being accredited to deliver the service; unable to access referrals promptly due to workload."*[186]

NHS Bedfordshire, Luton and Milton Keynes ICB identified the need for every pharmacy to have a member of staff with responsibility for ensuring "the pharmacist in charge actions (CPCS) referrals and records this". They suggested that funding for an accuracy checking pharmacy technician (ACT) would release pharmacists to focus on the CPCS.[187]

There was also variability between community pharmacies in whether they completed referrals they received via the CPCS and therefore received payment.[188] Two ICBs we heard from reported positive completion rates: NHS North East London ICB reported that 75% of CPCS consultations were completed within community pharmacy with only 2% referred back by the pharmacist,[189] and NHS Frimley Integrated Care reporting a community pharmacy completion rate for GP referrals of 62%, which they stated was above the national average but still required improvement.[190]

183 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
184 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
185 NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033) NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), Avon LPC (APE0017), British Oncology Pharmacy Association (APE0021), NHS Northamptonshire ICB (APE0023), National Pharmacy Association (APE0026), The NPA Women Members' Forum (APE0031)
186 NHS Black Country ICB (APE0014)
187 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
188 NHS Business Services Authority Community pharmacy advanced service specification: NHS Community Pharmacist Consultation Service (May 2023)
189 NHS North East London ICB (APE0024)
190 NHS Frimley Integrated Care (APE0020)

However NHS Gloucestershire ICB and NHS Dorset Integrated Care identified issues with the completion rate among community pharmacies, which some suggested was because the process for claiming is difficult for community pharmacy, especially given workforce shortages.[191] NHS Gloucestershire ICB said that claiming for the service was time-intensive for pharmacies, which made it difficult to monitor completion rates, and there was also variability in capacity to deliver the service consistently due to workforce shortages.[192] NHS Dorset Integrated Care similarly stated that low levels of claiming indicated implementation issues for community pharmacies.[193] The NPA and the NPA's Women's Forum stated that many referrals from the NHS 111 CPCS happen at the weekend, and in general it could be hard to manage referrals given their timing and volume is unpredictable.[194]

Overall, the evidence indicates that the NHS 111 referral pathway is fairly well embedded, however there is significant variability in the implementation of the CPCS, particularly in the GP referral pathway. This is due to limited engagement from PCNs and GPs compounded by IT difficulties and workforce shortages. The UEC referral pathway had only just begun, at the time of publication of this report. Notwithstanding this, we conclude that the commitment to deliver the CPCS has been met, and therefore rate this aspect of the commitment as 'good'.

Was the commitment effectively funded (or resourced)? Rating: Requires improvement

Based on the evidence we received from ICBs and trade associations including LPCs, there does not seem to be widespread agreement on whether the funding of the CPCS was adequate.

NHS Sussex Integrated Care stated that a significant amount of staffing and IT support and resource had been put into supporting the CPCS,[195] and a further ICB and Avon LPC stated that CPCS funding had been sufficient.[196]

However, several stakeholders indicated that the funding was insufficient given the requirements. For example, the PSNC reports that, despite significant efforts put into the implementation of the CPCS, the funding had not always been enough:

> *"Significant effort was put into supporting the implementation of referrals from NHS 111 by 111 providers, supported by local NHS organisations, LPCs, pharmacy contractors and NHS England. In many areas, the initial support from NHS organisations was not resourced well enough to achieve an optimal level of referrals in a timely manner.[…] NHS England did eventually commission more support for general practices to implement the referral pathway, but this arrived later than should have been the case and it lacked the scale that was required for an implementation programme of this size.*

191 NHS Gloucestershire ICB (APE0002), NHS Dorset Integrated Care (APE0027), NHS Frimley Integrated Care (APE0020), The Company Chemists' Association (APE0018)
192 NHS Gloucestershire ICB (APE0002)
193 NHS Dorset Integrated Care (APE0027)
194 National Pharmacy Association (APE0026), The NPA Women Members' Forum (APE0031)
195 NHS Sussex Integrated Care (APE0037)
196 Anonymised (APE0007), Avon LPC (APE0017)

> *[...] much of the support to embed GP referrals and to maintain levels over time has been provided by LPCs, as a means of indirectly supporting the local pharmacy contractors they represent."*[197]

The RPS's submission indicated that there had been a lack of resourcing and funding for project management to support engagement with the service as well as driving service implementation and delivery; a lack of additional investment in software to support referrals and enabling community pharmacy read/write access to patients' medical notes; and a lack of training investment for GP staff to implement the service.[198] NHS Bedfordshire, Luton and Milton Keynes ICB similarly reported that while there had been funding to conduct the CPCS, this did not include the required level of resource to integrate the service fully within NHS 111, general practice and secondary care.[199]

Regarding funding for the GP CPCS specifically, NHS Dorset Integrated Care said there had initially been very little funding at a CCG level to support its implementation.[200] NHS West Yorkshire ICB indicated that although there had been funding for the GP CPCS via the PhIF (see Chapter 5 for more information), they argued this was repurposed rather than new funding.[201] As indicated above, several ICBs reported that the IIF[202] provided PCNs with payments for referrals, and there were referral targets for PCNs within the IIF, however these targets were not always met.[203] NHS Surrey Heartlands ICB described how IIF targets had in fact had a negative impact on delivery of the service because PCNs that were failing to meet the target had no incentive to continue with the service.[204] Similarly, NHS Nottingham and Nottinghamshire ICB said that none of the PCNs achieved the IIF referral target, and the IIF scheme indicator for the CPCS has been removed for this year so PCNs cannot claim.[205] Three ICBs indicated that GP practices were now having to submit capacity and access improvement plans[206] as part of the IIF, and there may be opportunities to encourage CPCS within those.[207]

Several ICBs indicated they had received funding for a part-time member of staff from their LPC to support the implementation of the CPCS,[208] however NHS Nottingham and Nottinghamshire ICB stated this funding was only for a year. This ICB also had an additional year's funding for IT training support for GPs to use the referral templates on the GP systems, but again this was non-recurrent.[209] In their submission, Humber LPC stated that they obtained funding locally for pharmacists to support GPs in implementing the CPCS, but lack of ongoing support had meant this had not had the desired impact:

197 Pharmaceutical Services Negotiating Committee (APE0009)
198 Royal Pharmaceutical Society (APE0038)
199 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
200 NHS Dorset Integrated Care (APE0027)
201 West Yorkshire ICB (APE0034)
202 NHS England, Investment and Impact Fund, accessed 120623
203 NHS Dorset Integrated Care (APE0027), NHS Gloucestershire ICB (APE0002), NHS Surrey Heartlands ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023)
204 NHS Surrey Heartlands ICB (APE0006)
205 NHS Nottingham and Nottinghamshire ICB (APE0013)
206 NHSE, Network Contract DES – capacity and access improvement payment for 2023/24, 30 March 2023
207 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Black Country ICB (APE0014)
208 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS Leicester, Leicestershire and Rutland ICB (APE0033)
209 NHS Nottingham and Nottinghamshire ICB (APE0013)

> *"Locally we were successful in obtaining funding to deploy community pharmacists to assist practices with imbedding GP CPCS into their ways of working […] lack of direct and ongoing support meant they quickly defaulted back to non-engagement and regarded the training from pharmacists as part of their standard training package for every new join, rather than the safety net to support those having trouble self-actuating the service as originally intended […] The implementation of these things needs further work and funded support cooked in".*[210]

Submissions from several stakeholders were clear that an improved IT solution was necessary to deliver the service effectively and that NHS mail[211] was ineffective.[212] For example, NHS Nottingham and Nottinghamshire ICB and NHS Leicester, Leicestershire and Rutland ICB told us of anecdotal reports that community pharmacies did not have time to check NHS mail for referrals. They said that NHS mail referrals should be replaced with a system that is integrated with patient notes.[213] NHS Coventry and Warwickshire ICB said the multiple different systems used to implement the CPCS require resource-intensive work-arounds. From this they concluded that the IT aspect of the CPCS was not funded sufficiently.[214]

Six ICBs indicated that the absence of a national IT platform, and in particular the move from a national IT platform to locally funded systems, had hindered delivery of the service. The Suffolk and North Essex ICB stated that, as well as reducing CPCS uptake, the move to locally funded IT solutions for the service had been a retrograde step for the digital integration of community pharmacy with other services:

> *"[…] the decision to move from a single IT platform to a 'provider pays' model has reduced the visibility of the [Community Pharmacy Consultation] service which is a missed opportunity and represents a backwards step for better digital integration."*[215]

NHS West Yorkshire ICB similarly stated that the IT challenges in delivering the CPCS were symptomatic of wider digital integration problems they faced within the ICB:

> *"The implementation of the service has highlighted the continued issues we have with IT integration (between services)".*[216]

NHS Nottingham and Nottinghamshire ICB stated that NHSE had funded the introduction of a module within the EMIS system (an electronic patient record system widely used in primary care) to support referrals from GP. However the money had to be returned as GP practices did not claim for it, which meant only two of 12 GP surgeries within the ICB benefitted and there is no additional funding for other EMIS practices.[217] NHS Black

210 Humber LPC (APE0032)
211 NHS England, "NHSmail" accessed 220623.
Note: NHS mail is a secure email service approved by the Department of Health and Social Care for sharing patient identifiable and sensitive information.
212 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010) ,NHS Sussex Integrated Care (APE0037), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS North East London ICB (APE0024), NHS Dorset Integrated Care (APE0027), Community Pharmacy Lincolnshire (APE0022)
213 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Leicester, Leicestershire and Rutland ICB (APE0033)
214 NHS Coventry and Warwickshire ICB (APE0025)
215 NHS Suffolk and North East Essex ICB (APE0010)
216 NHS West Yorkshire ICB (APE0034)
217 NHS Nottingham and Nottinghamshire ICB (APE0013)

Country ICB reported that it was the ICB rather than NHSE, that had paid for all EMIS practices (78% of all GP practices in their ICB) to be able to use a local services referral button within EMIS to deliver the GP CPCS.[218]

Other ICBs also said they had invested significant funding into IT and staff training, at the ICB level.[219] For example NHS North East London ICB had provided £100,000 for training GP staff, £60,000 for a system enabling community pharmacy to know when a referral has come in, and two years' of funding for the IT system, amounting to 5p per patient across the ICB annually. Although their LPC felt this was sufficient, the ICB had concerns that this would need renewing in 2025 if the CPCS still received no national funding or IT integration support.[220]

We had reports of the positive impacts of ICBs being able to fund services locally. NHS Suffolk and North East Essex ICB stated that ICBs now having commissioning power will facilitate the further integration and collaboration between NHS 111 and pharmacies in their system.[221] Community Pharmacy Humber LPC described how they had obtained local funding for a successful innovation:

> *"Locally again we obtained funding for a pharmacy-initiated version of CPCS that proved very popular and actively triaged out many likely GP appointments."*[222]

NHS Gloucestershire ICB indicated that regionally, ICSs that had put in additional funding to the service had seen greater uptake, and stated that a different method of funding "at ICB/ CCG level and at GP practice level (with associated targets)" would have enhanced CPCS implementation. They were critical of the national funding model for the CPCS, which they said had resulted in GP practices, A&E services, and ICBs being insufficiently funded to implement the service, with GP practices in particular not having the "additional capacity" to deliver it.[223]

NHS Surrey Heartlands ICB told us that the referral process was not clear at the national level so ICBs had to fund and produce their own referral pathways, and this had delayed implementation.[224] The PSNC suggested that variable resourcing might affect implementation, stating that levels of CPCS referrals from different NHS 111 providers vary in ways that cannot be explained by variation in the populations served, which they stated suggests a variability in resourcing.[225]

From the perspective of community pharmacies, the CCA stated that the fee community pharmacies receive for a completed CPCS consultation was insufficient and warned this could impact on service continuation:

> *"It is a matter of concern that the CPCS will be expanded in May 2023 despite warnings from the pharmacy negotiator that no new or expanded services should be rolled out in 2023/24 unless extra funding is put into community pharmacies."*[226]

218 NHS Black Country ICB (APE0014)
219 NHS Sussex Integrated Care (APE0037), NHS North East London ICB (APE0024),
220 NHS North East London ICB (APE0024)
221 NHS Suffolk and North East Essex ICB (APE0010)
222 The Community Pharmacy Humber LPC (APE0032)
223 NHS Gloucestershire ICB (APE0002)
224 NHS Surrey Heartlands ICB (APE0006)
225 Pharmaceutical Services Negotiating Committee (APE0009)
226 The Company Chemists' Association (APE0018)

Several stakeholders commented that, although community pharmacy received funding for referrals via the CPCS, the pharmacy received no payment when patients self-referred to community pharmacy following NHS 111 advice or advice from a GP (i.e. outside of the service).[227] In addition, the British Oncology Pharmacy Association stated that more investment in community pharmacy was required to ensure there were sufficient staff who were trained to manage the referrals.[228] NHS Leicester, Leicestershire and Rutland ICB stated that "it would have been helpful" if funding had been set aside specifically for community pharmacies to have capacity to engage with local PCNs and practices.[229]

The Department submission states that the CPCS is funded as a National Advanced Service under the Community Pharmacy Contractual Framework (CPCF), agreed through negotiation with the Pharmaceutical Services Negotiating Committee (PSNC). The submission also points to the Delivery Plan for recovering access to primary care which commits to "an intention to invest to significantly improve the digital infrastructure between general practice and community pharmacy".[230]

The evidence available to us indicates that, despite funding and investment from NHSE and locally via ICBs and LPCs, this is insufficient to deliver the service given the scale of the IT and workforce challenges. Therefore, we conclude that the funding aspect for this commitment 'requires improvement'.

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Good

Stakeholders were generally positive about the impact the CPCS has had on patients and the wider health service, where the service was available and implemented.[231] As mentioned above, NHSE estimated that the service could save 20.4 million GP referrals per year,[232] however, the Department's submission indicated that since November 2019 around two million referrals have been made to CPCS.[233]

Some stakeholders mentioned the lack of data to support evaluation of the impact of the CPCS on different groups.[234] NHS Gloucestershire ICB indicated patients were largely unaware of the service.[235] A pharmacy professional in our roundtable discussions also made this point, adding that patients did not necessarily see the value in the service:

227 NHS Sussex Integrated Care (APE0037), Pharmaceutical Services Negotiating Committee (APE0009), Community Pharmacy Suffolk LPC (APE0029)
228 British Oncology Pharmacy Association (APE0021)
229 NHS Leicester, Leicestershire and Rutland ICB (APE0033)
230 Department of Health and Social Care (APE0039)
231 NHS Gloucestershire ICB (APE0002), Anonymised (APE0007), NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), NHS Northamptonshire ICB (APE0023), NHS North East London ICB (APE0024), NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027), NHS West Yorkshire ICB (APE0034), Pharmaceutical Services Negotiating Committee (APE0009), British Oncology Pharmacy Association (APE0021),The NPA Women Members' Forum (APE0031)
232 NHS England, Service Level Agreement and Service Specification for the General Practice Community Pharmacist Consultation Service (GP CPCS) (April 2020)
233 Department of Health and Social Care (APE0039)
234 Royal Pharmaceutical Society (APE0038), Community Pharmacy Suffolk LPC (APE0029), The NPA Women Members' Forum (APE0031), NHS Gloucestershire ICB (APE0002), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Northamptonshire ICB (APE0023)
235 NHS Gloucestershire ICB (APE0002)

> *"I think the process is tiring, cumbersome, frustrating for patients. I think CPCS is great but poorly marketed and advertised to the general population so they don't understand the utility and the value of CPCS. And they do sometimes think that they are being fobbed off to another service, and we don't as clinicians in the 111 service want to have that conversation with them and take these consultations. And I guess with the waiting time sometimes that can occur for 111, it can be very frustrating situation where you're waiting 12 hours for then someone to say, "You need to go to community pharmacy". So I can understand from a patient's perspective."*[236]

In the evidence we received, stakeholders expressed concerns that patients eligible for free prescriptions would not benefit from the CPCS if it required them to purchase over the counter (OTC) medications from community pharmacies rather than receiving medication free of charge via a prescription from a GP, for example.[237] NHS Leicester, Leicestershire and Rutland ICB also cited concerns from GPs that patients will not want to be referred via the CPCS if they did not want to purchase OTC from the pharmacy, and this was a barrier to implementing the GP CPCS within their area.[238]

In their submission, NHS Black Country ICB stated that they are in the area that is second highest in the country for deprivation and "one of a few areas nationally that provides a minor ailments scheme (Pharmacy First)" which allows it to cater for patients who cannot afford OTC medication.[239] Many stakeholders were positive about the approach announced in May 2023 as part of the Delivery plan for recovering access to primary care recovery plan whereby community pharmacies will be able to supply prescription-only medicines for seven common conditions.[240] An ICS Chief Pharmacist in our roundtables also made the point that encouraging people to go directly to pharmacies without a referral would be preferable:

> *"[…] if we could take out the referral process and actually encourage people to go to their pharmacy first, that would make a really big difference in the way the pathway follows. And it would avoid the clunkiness of having to have a referral. And—talking to our local community pharmacies—they say that would make them feel more valued as well. Because people can walk in and, you know, you've got that real pharmacy-first working."*[241]

Another pharmacy professional whose role is to oversee a PCN told us that, in order to improve the service, more data is needed to understand why patients do not turn up to the pharmacy after being referred:

> *"So we want to see why people aren't turning up. So it might be that there's been an appropriate referral but that for whatever reason they haven't turned up or there's been a delay and so they can't come till the next day and by*

236 Stakeholder roundtables

237 NHS Gloucestershire ICB (APE0002), NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS North East London ICB (APE0024), NHS Leicester, Leicestershire and Rutland ICB (APE0033),NHS Sussex Integrated Care (APE0037), National Pharmacy Association (APE0026)

238 NHS Leicester, Leicestershire and Rutland ICB (APE0033)

239 NHS Black Country ICB (APE0014)

240 NHS Sussex Integrated Care (APE0037), Pharmaceutical Services Negotiating Committee (APE0009), The Company Chemists' Association (APE0018), Royal Pharmaceutical Society (APE0038)

241 Stakeholder roundtable

> *that time they've decided to phone a friend or present to A&E [Accident and Emergency] etc. So from that point of view, however we record an incident or a dropped referral I think at the moment it's not being captured properly from what I see from that freetext box. So it'll be good to have that as something integrated so it is in line with PSIRF [Patient Safety Incident Response Framework]. So there is that governance, we do have an idea of what kind of incidents are occurring as a result. So does it relate to you know, lack of access and so on? Because not all pharmacies are open because there's been a change to their contract hours as well."*[242]

The Department's submission states that patient satisfaction with the CPCS remains high (greater than 85%) and that 90% of patients who are referred to pharmacy are treated satisfactorily by the pharmacist, and 10% are referred to more urgent care.[243] However NHS West Yorkshire ICB told us that "bounce-backs" from community pharmacy to other services are a barrier to the implementation of the CPCS, especially around common conditions that require a prescription such as some ear nose and throat conditions.[244]

The Department's submission reports that each CPCS referral releases a 10-minute appointment for treatment of "more complex patients", the implication being that the service benefits patients by freeing up more GP time.[245] However, as mentioned above, some stakeholders described concerns from some general practice and specialist settings, about the potential patient safety risks of referring patients directly to community pharmacy.[246]

The Department's submission highlights an evaluation of a pilot of the CPCS UEC referral pathways, which estimated that 7,400 patients per month could be directed from Emergency Department (ED)/ UTC (Urgent Treatment Centre) sites to the CPCS in community pharmacies. This evaluation also showed that only 7% of patients referred to CPCS were escalated for urgent care, with 93% referrals successfully completed in a community pharmacy setting. The Department states that evidence also suggests a slow change in future patient behaviour, and more informed patient access choices, demonstrating the impact of the service.[247]

Our rating of 'good' for the impact that the commitment has had on patients and people in receipt of patient care is due to the widespread positive comments we received from stakeholders about the service when it is implemented, although patchy uptake has limited the service's potential to achieve optimal positive impact and there are concerns about people who are exempt from prescription charges not benefitting as much from the service.

242 Stakeholder roundtables
243 Department of Health and Social Care (APE0039)
244 NHS West Yorkshire ICB (APE0034)
245 Department of Health and Social Care (APE0039)
246 Anonymised (APE0007), Avon LPC (APE0017), NHS Nottingham and Nottinghamshire ICB (APE0013),
247 Department of Health and Social Care (APE0039)

Was it an appropriate commitment? Rating: Good

Stakeholders were generally positive about community pharmacy providing more clinical support to patients and relieving the pressure on other parts of the health service.[248] For example, NHS Gloucestershire ICB stated:

> *"This commitment is moving healthcare in the right direction, with community pharmacies managing more of the low acuity patients leaving General Practice to manage more complex issues. This will ultimately lead to meaningful improvement."*[249]

The commitment was however criticised for not including better incentives for referrals from providers or specific targets.[250] NHS Dorset Integrated Care wrote that the incentives were not present in the system to achieve the desired implementation:

> *"GP practices and hospitals need to refer for DMS and CPCS, but are not mandated to do it. even with contractual levers the GPs and hospitals are not necessarily taking part"*[251]

NHS North East London ICB reported that the initiative helps reduce pressure on general practice, and also can highlight to patients the importance of community pharmacies in giving advice, so long as patients understand the service and the referral pathway is simple. However, they stated that in their view, the commitment was not wide enough in scope and should include a minor ailments scheme to serve those who need an OTC medication but are in receipt of free prescriptions, and should cover more common conditions. They added that the commitment includes no targets, which means that as an ICB they do not know whether they are on track to deliver the service.[252] NHS West Yorkshire ICB similarly criticised the lack of indication within the commitment about the desired level of uptake of the CPCS:

> *"The commitment refers to delivery, without an indication of ambition of scale. For example, is the commitment to have all A&Es use CPCS in the longer term?"*[253]

Although they welcomed the commitment, Pharmacy2U, a distance selling pharmacy (DSP), stated that it overlooked the potential input DSPs can have in providing the CPCS on a national level:

> *"The role of Pharmacy2U, and other DSPs, in supporting the CPCS has so far been severely restricted. The CPCS currently organises referrals based on*

248 NHS Gloucestershire ICB (APE0002), NHS Surrey Heartlands ICB (APE0006), Anonymised (APE0007), NHS Nottingham and Nottinghamshire ICB (APE0013),NHS Black Country ICB (APE0014), Greater Manchester Integrated Care (APE0016), NHS Northamptonshire ICB (APE0023), NHS North East London ICB (APE0024), NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), Avon LPC (APE0017) The Company Chemists' Association (APE0018), British Oncology Pharmacy Association (APE0021), Royal Pharmaceutical Society (APE0038), Pharmacy2U (APE0015)

249 NHS Gloucestershire ICB (APE0002)

250 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS North East London ICB (APE0024), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033)

251 NHS Dorset Integrated Care (APE0027)

252 NHS North East London ICB (APE0024)

253 NHS West Yorkshire ICB (APE0034)

> *patient and pharmacy postcode, which means that DSPs are restricted to providing this service only to patients within the local area of their registered office, despite having national reach."*[254]

The NPA's Women Members Forum, Humber LPC and NHS Sussex Integrated Care indicated that patients being accessing the service directly was more appropriate than a system based on referrals.[255]

The Department's submission states that the service is viewed positively by providers, seeing it as a natural extension of the skills and service provided every day to walk-in patients; and supporting channel shift to community pharmacy from urgent care and primary care, releasing clinician time for more appropriate patient care.[256]

We rated the appropriateness of the commitment as 'good' because it is seen to support a move in the right direction towards community pharmacy managing minor conditions, freeing up other parts of the health service to manage patients with more complex conditions.

Commitment 2: The Discharge Medicines Service

Overall Commitment Rating and Overview of the Discharge Medicines Service: Requires improvement

This commitment is to introduce the DMS, an essential service which first appeared in Year 3 of the CPCF in August 2021.[257] The purpose of the DMS is to enable NHS Trusts to refer patients to community pharmacies for extra guidance around newly prescribed medicines. The DMS aims to reduce avoidable harm from medicines and reduce hospital readmissions.[258]

The DMS has three stages. These are undertaken within community pharmacy by pharmacists and pharmacy technicians, in any order (or simultaneously) and all must be undertaken for the DMS to be complete:

(1) Receive a discharge referral electronically from hospital.

(2) Receive the first prescription following the patient's discharge from hospital.

(3) Check the patient's understanding of the medication they are prescribed and give relevant advice.[259]

Overall, our rating of this commitment is that it 'requires improvement'. We consider the commitment, as worded, is focused on introducing the service. According to the evidence we received, the DMS can be beneficial to patients and the health service, but implementation of the DMS is negatively affected by IT problems. These problems exist within the trusts making the referrals, as well as within community pharmacists

254 Pharmacy2U (APE0015)
255 The Community Pharmacy Humber LPC (APE0032), The NPA Women Members' Forum (APE0031), NHS Sussex Integrated Care (APE0037)
256 Department of Health and Social Care (APE0039)
257 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021
258 House of Commons Library Research Briefing, Future of Community Pharmacies, June 2022
259 Pharmaceutical Services Negotiating Committee Discharge Medicines Service, accessed 120623

receiving the referrals. These problems are compounded by staff shortages, particularly within hospitals, and by lack of funding. Although the DMS is an Essential service for community pharmacies, the service is not mandatory for hospitals, which, in addition to the challenges mentioned above, results in patchy provision. Together, this evidence indicates that improvement is required to ensure the DMS is implemented effectively.

Was the commitment met overall (or on track)? Rating: requires improvement

The PSNC and NHS Surrey Heartlands ICB stated in their submissions that DMS had been successfully commissioned, on schedule, and with a clear national deadline.[260] NHS Gloucestershire ICB however indicated that they were not aware of any national fixed deadline or targets for acute trusts to make DMS referrals.[261]

It was clear from the submissions we received that there was significant variability in the number of referrals that community pharmacies receive from different hospital trusts, and this variability exists even between trusts within the same ICS.[262] Several stakeholders stated that the commitment would not be met due to IT difficulties within hospitals and community pharmacies,[263] due to workforce issues,[264] and/or due to a lack of incentives within trusts to make referrals as part of the DMS (which is not mandatory).[265]

In our roundtables, a hospital pharmacy professional characterised her hospital as "slow adopters" of DMS, and told us how staffing shortages and lack of funding in her hospital was preventing them using the DMS effectively:

> *"We're quite understaffed as a department here and so releasing staff and time in order to do this has been quite a challenge. And there has been no real funding to support that facilitating of it. So at the minute we're only using it for dosette boxes and discharging. So it's still quite a limited model really within our community area because I think we have just struggled with that funding attachment for secondary care to facilitate this. But we have seen the certain benefits of it for the dosette box patients, but we aren't doing it for anything further."*[266]

260 NHS Surrey Heartlands ICB (APE0006), Pharmaceutical Services Negotiating Committee (APE0009)

261 Pharmaceutical Services Negotiating Committee (APE0009)

262 NHS Surrey Heartlands ICB (APE0006), Anonymised (APE0007), Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), Pharmacy2U (APE0015), Avon LPC (APE0017), The Company Chemists' Association (APE0018), NHS Northamptonshire ICB (APE0023), National Pharmacy Association (APE0026), NHS Dorset Integrated Care (APE0027), The Pharmacists' Defence Association (APE0030), Royal Pharmaceutical Society (APE0038)

263 NHS Gloucestershire ICB (APE0002), NHS Nottingham and Nottinghamshire ICB (APE0013), The Company Chemists' Association (APE0018), NHS Frimley Integrated Care (APE0020), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), The NPA Women Members' Forum (APE0031), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

264 NHS Surrey Heartlands ICB (APE0006), Avon LPC (APE0017), Community Pharmacy Suffolk LPC (APE0029), NHS Dorset Integrated Care (APE0027 Anonymised (APE0007), The Company Chemists' Association (APE0018), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

265 NHS Surrey Heartlands ICB (APE0006), NHS Black Country ICB (APE0014), NHS Nottingham and Nottinghamshire ICB (APE0013), The Company Chemists' Association (APE0018), NHS Dorset Integrated Care (APE0027), The Pharmacists' Defence Association (APE0030), NHS Leicester, Leicestershire and Rutland ICB (APE0033) NHS Sussex Integrated Care (APE0037)

266 Stakeholder roundtables

Four ICBs told us that the IT systems used by hospitals in their ICS were unable to process referrals and/or were incompatible with the IT systems used in community pharmacy.[267] The PSNC also stated that some trusts did not have access to support to upgrade digital systems and IT, and would therefore not be able to meet the commitment.[268] NHS Suffolk and North East Essex ICB indicated that this commitment would be easier to meet for those trusts that already had systems in place for e-prescribing and the infrastructure set up for obtaining consent from patients to use the service digitally.[269] Echoing this, NHS Frimley Integrated Care explained that problems with their electronic prescribing system meant they were using NHS mail for some DMS referrals.[270] However Lincolnshire LPC indicated that NHS mail could not manage the volume of referrals that community pharmacies were receiving via the DMS and other services.[271]

A participant in our roundtable discussions explained how a lack of integration and interoperability between hospital and community pharmacy IT systems made the DMS cumbersome to implement:

> *"[…] we're currently running a system whereby there is additional steps to undertake logging onto a website, logging on patient details, checking with the community pharmacy, getting an F code, doing emails through. And it's very laborious. The Holy Grail is that it's all integrated within Cerner or Epic, and it's all done automatically as part of the discharge."*[272]

We also received evidence suggesting there were IT challenges within community pharmacies. NHS Gloucestershire ICB stated that pharmacies were having to use two different IT systems to manage the DMS, which took too long and resulted in them not taking up referrals.[273] Other stakeholders also described the lack of accurate data from community pharmacy about the level of referrals from trusts because IT issues hamper their ability to provide accurate information.[274] NHS Bedfordshire, Luton and Milton Keynes ICB described how a lack of staff to make referrals together with IT issues made it challenging for their Acute Trusts to implement the DMS. This was compounded by community pharmacies not actioning referrals which then frustrated Trust staff and deterred them from using the system.[275]

Pharmacy2U stated that the educational material provided to pharmacies to support them to implement the DMS was of high quality,[276] but that the materials did not seem to be rolled out consistently across the country. They called the provision a "postcode lottery", a characterisation echoed by the NPA.[277]

The Department's submission admits that as hospitals were busy dealing with recovery from the pandemic in 2021 as well as circulating Covid-19 and influenza, there was a

267 NHS Surrey Heartlands ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Gloucestershire ICB (APE0002), NHS Black Country ICB (APE0014), Community Pharmacy Suffolk LPC (APE0029)
268 Pharmaceutical Services Negotiating Committee (APE0009)
269 NHS Suffolk and North East Essex ICB (APE0010)
270 NHS Frimley Integrated Care (APE0020)
271 Community Pharmacy Lincolnshire (APE0022)
272 Stakeholder roundtables
273 NHS Gloucestershire ICB (APE0002)
274 NHS Sussex Integrated Care (APE0037), Community Pharmacy Suffolk LPC (APE0029), Pharmaceutical Services Negotiating Committee (APE0009)
275 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
276 Pharmacy2U (APE0015)
277 National Pharmacy Association (APE0026)

negative impact on developing the hospital referral pathways to community pharmacy and maximising the impact that this service could make. However, the Department's submission also states that it had continued to provide educational material to assist in uptake, and that it is developing an automated claims process for community pharmacy which it hopes will improve ease of claims and data collection. The submission also set out that as of January 2023, community pharmacy had claimed for around 216,700 patient referrals from hospital through the DMS service, with more referrals seen for patients from "lower indices of multiple deprivation".[278]

Overall, we conclude that the commitment has not been fully met and therefore we rate this aspect of the commitment as 'requires improvement'.

Was the commitment effectively funded (or resourced)? Rating: requires improvement

Many stakeholders agreed that they had been funded to carry out the service, but there had been insufficient resource and funding to overcome the barriers to uptake. These barriers included adequate levels of workforce, IT infrastructure and lack of referrals from hospital trusts.[279] Some stakeholders suggested that further funding to support IT integration and functionality would have been useful.[280] NHS Bedfordshire, Luton and Milton Keynes (BLMK) ICB stated that adequate resourcing from ICBs to implement the service might be challenging in the face of limited overall funding or competing priorities. Describing the significant challenges they faced within their own ICB, they wrote:

> *"We also cannot underestimate the financial climate that BLMK ICB and all our partners across the system are operating in. The workforce crisis, junior doctors and nursing strikes and the requirement to be on OPEL 4[281] are all factors that are affecting the engagement with this service."*[282]

Several stakeholders pointed out that the DMS is not mandatory for hospital Trusts and is incentivised via a Commissioning for Quality and Innovation (CQUIN) target.[283] NHS Surrey Heartlands ICB reported that because the DMS is not mandated for Trusts, it has not been prioritised and therefore the deadline for implementation has not been met locally.[284] Many stakeholders also commented that the CQUIN targets of 0.5% and 1.5% were too low to work as an effective incentive for Trusts to implement the DMS.[285] There were also concerns that Trusts did not always receive funding via the CQUIN because community pharmacies did not always complete the referrals because of the difficulties they experienced in claiming.[286] For example, NHS Gloucestershire ICB wrote:

278 Department of Health and Social Care (APE0039)

279 NHS Gloucestershire ICB (APE0002), Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk and North East Essex ICB (APE0010), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

280 NHS Surrey Heartlands ICB (APE0006), NHS Dorset Integrated Care (APE0027)

281 Note: The Operational Pressures Escalation Levels (OPEL) Framework was introduced by the NHS in 2016 to categorise the operational challenges faced by hospitals. OPEL 4 is the highest level and indicates "Pressure in the local health and social care system continues and there is increased potential for patient care and safety to be compromised."
NHS England 'Operational Pressures Escalation Levels Framework' December 2018

282 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

283 NHS Frimley Integrated Care (APE0020), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038)

284 NHS Surrey Heartlands ICB (APE0006)

285 NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS Leicester, Leicestershire and Rutland ICB (APE0033)

286 Avon LPC (APE0017), NHS Northamptonshire ICB (APE0023), Anonymised (APE0007)

> *"The CQUIN target was measured in numbers of claims by Community Pharmacists. This did not reflect the actual success of the project as this was extremely under- reported as the claims process was so difficult and time consuming. The referral numbers from the acute trust would have been a better indicator of success (or both)".*[287]

Another participant explained how, in their Trust there was a desire to use the DMS, but the low CQUIN target in their Trust, together with cumbersome IT systems, hampered efforts:

> *"We've been pushing it big time in paediatrics. The trouble is, I think it was 0.5% of patients we wanted… there was something about… we actually said every single one of our patients should be on the system. It feels as if it's a system that, particularly with unlicensed medicines and all these sorts of things, it should have so much being pushed through it. And yet it actually takes quite a long time to put somebody onto the system."*[288]

Other stakeholders were positive regarding the funding for this commitment and pointed to funding available to allocate a part-time (whole time equivalent, WTE 0.2) band 7 member of staff to support Trusts to project-manage the DMS scheme.[289] However Black Country ICB stated that this was insufficient to embed the service.[290] NHS Frimley Integrated Care stated it was "waiting for authorisation to start the recruitment process".[291] Both NHS Nottingham and Nottinghamshire ICB and Suffolk LPC suggested they had been unable to recruit for this role and therefore been unable to claim the funding.[292]

The Department's submission sets out that:

> *"DMS is funded as an essential service as agreed within the CPCF, with no cap on the numbers that can be provided, and as such is available from all community pharmacies".*[293]

However some stakeholders questioned whether community pharmacy was getting enough funding to meet this commitment, given the fact it is an Essential service that pharmacies are required to provide and is funded from within the global sum allocated to community pharmacy in the CPCF, with no new or additional funding.[294]

Based on the evidence available to us, we conclude that the funding aspect for this commitment 'requires improvement'. While funding is available, there is insufficient support for the IT systems needed to deliver the DMS effectively, insufficient incentives for Trusts to implement the DMS, and concerns from stakeholders about the level of funding available to community pharmacies to deliver this Essential service.

287 NHS Gloucestershire ICB (APE0002)
288 Stakeholder roundtables
289 NHS Black Country ICB (APE0014), Avon LPC (APE0017), NHS Frimley Integrated Care (APE0020), NHS Northamptonshire ICB (APE0023), NHS Leicester, Leicestershire and Rutland ICB (APE0033)
290 NHS Black Country ICB (APE0014)
291 NHS Frimley Integrated Care (APE0020)
292 NHS Nottingham and Nottinghamshire ICB (APE0013), Community Pharmacy Suffolk LPC (APE0029)
293 Department of Health and Social Care (APE0039)
294 NHS Gloucestershire ICB (APE0002), Professor Ian Maidment, Aston University (APE0004), Pharmacy2U (APE0015), Community Pharmacy Suffolk LPC (APE0029), NHS Sussex Integrated Care (APE0037)

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Good

The majority of stakeholders who addressed this point agreed that the commitment, where implemented, delivered positive impacts for patients, people in receipt of social care, and carers.[295]

In roundtable discussions we heard from hospital pharmacy professionals who were very positive about the impact of the DMS on patients and on their colleagues in community pharmacy:

> *"I think it's the issues that it identifies around high-risk medicines, other medicines, discrepancies [that make the DMS valuable]. You know, we're actually making a difference to patients. And even the feedback from the community pharmacy end is, "it's so helpful..." […] this is absolutely integration. And it's also built the relationship between the hospital trust and the community pharmacies because when we set it up, we did training and it's that getting to know people, resolving things. […]"*[296]

Another participant in roundtable discussions also described how the DMS supported integration between hospital and community pharmacy to benefit patients:

> *"[…] if you've got patients getting discharged on strong opioids and you're not wanting them to continue long term, you're getting a clear message to that community pharmacy where they go month-in month-out that obviously they shouldn't be continuing, and the right message is getting there, so you're singing from the same hymn sheet basically, and passing that message on. And it's also the importance around efficiency as well, if you're putting people on blister packs, or you're giving a patient blister packs, it gives that community pharmacy time as well to prepare blister packs as well so they know what changes are happening and they're not retrospectively waiting for the GP to do the reconciliation there and then get a prescription last minute and then they need a new blister pack."*[297]

However, we also heard from others who, despite thinking the DMS was a valuable service, identified implementation challenges due to the referral system:

> *"We've tried to have a good step-up of [the DMS] over the last six months. And it's been really hit and miss and whether or not you can easily identify what the reason for referral is, and then if you can actually get the pharmacy to see it and not reject it because the patients have moved or not actually come to them due to the way our patient flow works. There's different ways of discharging patients now from hospital that make a lot of those high-risk*

295 NHS Gloucestershire ICB (APE0002), Anonymised (APE0007), NHS Surrey Heartlands ICB (APE0006), Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), Avon LPC (APE0017), The Company Chemists' Association (APE0018), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), NHS Coventry and Warwickshire ICB (APE0025), The NPA Women Members' Forum (APE0031) , NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038)

296 Stakeholder roundtables

297 Stakeholder roundtables

> *patients who need ongoing care assessments not actually go home, so they don't get the referral because they haven't gone home, they've gone to another care facility. And there was so much reporting of that, that we find just gets bounced back to us."*[298]

Another roundtable participant explained the challenges with accurately transferring patient information from hospital to community pharmacy:

> *"Our biggest challenge is quality of data on transfer. The system's integrated, you still have to put the F numbers in and fill out the form, but it does integrate. But when the patient is discharged and that data transfers, sometimes the output from the system is almost like gobbledygook, which means referrals are then getting bounced back."*[299]

NHS Surrey Heartlands ICB reported high patient satisfaction with the service.[300] Suffolk LPC however pointed out that the DMS is still a health service, that the link with social care has not been outlined adequately and there is currently no requirement to do this.[301] NHS Bedfordshire, Luton and Milton Keynes ICB similarly reported a lack of evidence that care home residents or carers for patients receiving home care were benefiting from the DMS "as they do not often go to the pharmacy themselves". They also identified lack of patient engagement and consent as a barrier to implementing the service.[302]

A number of submissions pointed to evidence indicating that the DMS had avoided a significant number of hospital re-admissions,[303] mostly based on data from pilot studies in local areas.[304] For example, the PSNC stated:

> *"The evidence base for this service, from the academic evaluations of pilot services suggests the DMS is highly valuable to patients and to the NHS, including significant improvements in patient safety and the creation of significant health economic benefits to the NHS."*[305]

NHS Suffolk and North East Essex ICB reported national data which they stated:

> *"[…] consistently suggests that ~20% of DMS referrals result in the detection of a potential safety incident which supports the value in continuing and expanding the service for wider benefit."*[306]

NHS Gloucestershire ICB indicated that they were prioritising high risk patients for referrals and are working locally to find ways to measure the impact on patients.[307] NHS Suffolk and North East Essex ICB also stated that the DMS was currently only used for some groups of patients, but they were exploring capacity to expand to other patient groups.[308]

298 Stakeholder roundtables
299 Stakeholder roundtables
300 NHS Surrey Heartlands ICB (APE0006),
301 Community Pharmacy Suffolk LPC (APE0029)
302 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
303 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Northamptonshire ICB (APE0023), NHS Sussex Integrated Care (APE0037)
304 The Company Chemists' Association (APE0018), Royal Pharmaceutical Society (APE0038), NHS Black Country ICB (APE0014), Pharmaceutical Services Negotiating Committee (APE0009), Pharmaceutical Services Negotiating Committee (APE0009)
305 Pharmaceutical Services Negotiating Committee (APE0009)
306 NHS Suffolk and North East Essex ICB (APE0010)
307 NHS Gloucestershire ICB (APE0002)
308 NHS Suffolk and North East Essex ICB (APE0010)

A paper by Nick Thayer (an academic and Head of Policy for the CCA) and colleagues published in the Journal of Pharmaceutical Health Services Review in April 2023, looked at DMS referrals and claims rates and estimated the impact of the DMS on hospital readmissions, analysing national DMS claims data from March 2021 to February 2022. They found DMS referral rates varied significantly between ICSs, from 509/10,000 admissions to fewer than one per 10,000. They also found that only 43% of pharmacies had claimed for a DMS (complete or incomplete), and that the level of claims varied substantially between pharmacies. The authors used this information together with evidence from previous study data to model the impact of DMS on hospital readmissions. They estimated the DMS had resulted in over 8000 fewer hospital readmissions after 30 days, and nearly 6000 fewer readmissions after 90 days. They estimated that if all ICS areas were as active as the highest performing area, the DMS would avoid over 29 000 readmissions after 90 days every year.[309]

Some stakeholders argued that the unequal uptake of the DMS by hospitals meant that some patients and people in receipt of social care would not benefit from it.[310] Pharmacy2U argued that the practical roll-out (and the issues associated with it) is an issue, as many patients state to not have been informed about this service. Pharmacy2U also said that:

> *"[…] a significant postcode lottery in access to DMS consultations, as uptake of the service varies widely across England: we receive regular referrals from some hospitals, and none from others."*[311]

The Department's submission refers to the total number of people who have used the service asserting that more referrals have been seen for patients from lower indices of multiple deprivation, and stating that:

> *"[…] extrapolating our data to Jan 2023, we estimate between 9,420 and 21,667 readmissions have been avoided since the service started".*[312]

Several hospital professionals in our roundtables were very positive about the impact of the DMS. One participant said that within their trust work on a discharge service had been ongoing for over 10 years. It was now working well, and the demonstrable reduction in readmissions was creating a case for supporting the service financially and technologically within the hospital:

> *"I mean, we've been trying to get this off the ground since I think about 2012/2013 so you know we've had a bit of a head start compared to peers. But we've got to a point where our systems are integrated and for every patient that has any pharmacy contact will have a DMS if they consent to it. So, we're really transferring at scale. […] And just for the last financial year, we've actually avoided in excess of 400 admissions. Now that suddenly does facilitate that finance and it gets people to sort of sit up. And gets in the IT buy-in and the finance buy-in. Because when you've already got 20 ambulances queuing, you don't want another 400 patients adding to that. And obviously then there's the readmission penalties or the patient harm and*

309 Thayer, Mackridge and White. Predicting the potential value of the new discharge medicines service in England. Journal of Pharmaceutical Health Services Research. Advance access, accessed 19062315 April 2023.

310 NHS Dorset Integrated Care (APE0027), The NPA Women Members' Forum (APE0031) , NHS Black Country ICB (APE0014),

311 Pharmacy2U (APE0015)

312 Department of Health and Social Care (APE0039)

all the rest of it that goes with it."[313]

We have rated this commitment as 'good' in terms of the impact that the commitment has had on patients and people in receipt of social care, because of the significant benefits the DMS can bring to the NHS and patients where it is implemented, as evidenced in pilot studies. However, we also recognise that uneven uptake of the service limits the benefits in practice. Concerningly, we received little evidence about the governance of the DMS and processes for ensuring risks and errors are reported, monitored and fed back to ensure learning.

Was it an appropriate commitment? Rating: Requires improvement

Stakeholders recognised the positive benefits for patients and people in receipt of social care, as referenced in the sections above. Pharmacy2U stated that DMS is "a pivotal bridge between secondary and primary care, and rightly recognises the expertise of pharmacy in supporting patients to understand their medication, preventing harm, and reducing readmissions."[314]

However, some stakeholders pointed out that fact that the DMS is not mandatory for hospitals is likely to be the cause of variable referral rates between hospitals. Humber LPC stated that because community pharmacies rely on referrals from hospitals to implement the DMS, and referral rates are often low, this poses a barrier to implementation:

> *"[…] a pharmacy service that is initiated by others, and at such low volumes that it struggles to be integrated as 'business as usual'".*[315]

NHS Sussex Integrated Care similarly suggests that the scope of commitment is too narrow and "needs to be a wider commitment so that all parts of the system are engaged in the service and have the appropriate IT infrastructure to deliver the service."[316] Care England stated that:

> *"It is not sufficient to commission any service. There is a need for clear targets, implementation support, and recognition of successes and failures."*[317]

The Department's submission does not address these points specifically, but states that the DMS is an Essential service and provides information on referral numbers.[318]

We rated the appropriateness of the commitment as 'requires improvement' because, despite the benefits and potential benefits for patients and people in receipt of social care, the service is not mandatory for hospitals which limits the capacity for them to work with community pharmacy in an integrated way. In our judgement, the commitment to introduce the DMS is not sufficient without also putting in place the support required to ensure its effectiveness.

313 Stakeholder roundtables
314 Pharmacy2U (APE0015)
315 The Community Pharmacy Humber LPC (APE0032)
316 NHS Sussex Integrated Care (APE0037)
317 Care England (APE0019)
318 Department of Health and Social Care (APE0039)

3 Hospital pharmacy

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024.	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation.	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement

In this section we provide an assessment of Government commitments in relation to hospital pharmacy. Two commitments were selected for evaluation:

"To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024."

"To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation."

These commitments are summaries of other commitments made in Government documents, outlined in the correspondence we received from the Minister when enquiring about the commitments Government had made in relation to pharmacy.[319]

At their core, both commitments are part of the Government's aim to modernise hospital pharmacy services and make them safer and more effective for patients. The first commitment focuses on the aim to fully digitise prescribing in hospitals, and to introduce digital prescribing across the NHS by 2024. The second commitment sets out an aim to "optimise" NHS aseptic services, which the Government envisions will deliver better

319 Correspondence from the Parliamentary Under Secretary of State for Primary Care and Public Health on the Expert Panel's Independent Evaluation in the Area of Pharmacy (3 April 2023)

clinical outcomes which in turn would positively impact both patient experience and levels of productivity.[320]

Commitment 1: Electronic prescribing

Overall Commitment Rating and Overview of Electronic prescribing: Inadequate

The commitment first appeared in the NHS Long Term Plan, published in January 2019,[321] and was subsequently outlined in a Departmental press release in November 2020.[322]

Electronic prescribing in basic terms means that the prescription for a medication exists as a digital document, which is electronically sent to an individual's dispensing pharmacy, or in the case of an inpatient in hospital made available to the healthcare staff supplying or administering the medication during the patient's stay in hospital. Electronic prescribing also means that individuals with repeat prescriptions can collect it from their pharmacy without having to visit their GP and will not have to worry about keeping track of a prescription in paper form.[323]

According to the NHSE website, the benefits of electronic prescribing for dispensers include efficient processing of prescriptions, less paperwork, better stock control and improved patient satisfaction.[324] A Department press release from November 2020 stated that electronic (digital) prescribing increases the speed at which clinical staff can access information about patients' prescribed medicines and medical history and can "reduce medication errors by up to 30% when compared with the old paper systems", as well as saving time and money for the NHS.[325]

There are pockets of excellence in the roll-out of electronic prescribing, but three factors in particular limit progress on delivering this commitment. Integral to successful roll-out of electronic prescribing is the digital maturity (see definition of digital maturity in the executive summary) and capability of providers. In the evidence we have received, it is clear that many stakeholders experience issues in ensuring a basic, adequate level of digital maturity which in turn many suggest has impeded the progress of this commitment.

During our previous evaluation of the digitisation of the NHS,[326] we found that the digital maturity of Trusts was highly variable. Reliance on local as well as national funding has led to uneven digital maturity as providers respond to increased demand and pressure on services. In addition, the current focus on IT systems pays too little heed to optimising training and systems of medicine management to ensure that electronic prescribing is integrated and successful. Moreover, the explicit wording of the target of this commitment to "eliminate" paper prescribing, will not be met and to do so in the set timeframe was and remains neither realistic nor appropriate. This chapter sets out the reasoning for our conclusions in more detail.

320 Department of Health and Social Care (APE0039)
321 NHS, NHS Long Term Plan, January 2019.
322 DHSC, "£16 million to introduce digital prescribing in hospitals", 18 November 20202
323 NHS England, Electronic prescriptions for prescribers, accessed 130623
324 NHS England, Electronic prescriptions for dispensers, accessed 130623
325 DHSC, "£16 million to introduce digital prescribing in hospitals", 18 November 2020
326 Health and Social Care Committee's Expert Panel Fourth Special Report Evaluation of Government commitments made on the digitisation of the NHS, HC 780

Was the commitment met overall (or on track)? Rating: Inadequate

Some ICBs we heard from stated that they are on track to meet this commitment.[327] NHS Coventry and Warwickshire ICB stated that one of their Trusts would have electronic patient records fully rolled out by October 2023 (including electronic prescribing) whilst the other Trust in their ICB would implement the same systems from 2024/25.[328] NHS Dorset Integrated Care stated that the commitment was on track, but that:

> *"EPMA [Electronic Prescribing and Medicines Administration] in inpatient NHS units is progressing, but electronic transmission to community pharmacy [is] not yet available."*[329]

The majority of ICBs and LPCs who submitted evidence to us stated that the commitment had not been met in many areas due to poor digital maturity.[330] NHS Suffolk and North East Essex ICB declared that one of its Trusts considers itself "digitally undeveloped with a current estate of disparate systems", whilst another is identified as "digitally mature". This illustrates the differing levels of digital capability, even within one single ICB.[331]

In their evidence, NHS Black Country ICB stated that uptake of digital prescribing varies between different systems, and that some EPMA systems do not eliminate paper due to functionality, which leads to what they call a "mixed economy".[332] According to the PDA:

> *"PDA members tell us that steady progress is being made, however digital prescribing being introduced across all hospitals by 2024 is unlikely to be achieved. The developments are patchy across the geography and there is huge variation from NHS Trust to NHS Trust with some having already achieved this aim over 5 years ago."*[333]

The RPS's submission similarly concluded that they think the commitment is unlikely to be met across the board by 2024, stating:

> *"We have heard that even where electronic prescribing has been implemented there are still areas across some Trusts that are not using electronic prescribing due to poor capability of the system to provide the functionality needed, such as A&E departments and outpatients. Even those patients prescribed medication digitally may also be prescribed medication on paper."*[334]

During our stakeholder roundtable, many of the healthcare professionals told us that paper prescribing was still very common. One of the participants stated that some aspects of their medication was available through an electronic prescription, whilst another said they still needed to call up their GP practice to renew. A secondary care professional at the roundtable told us:

---

327 NHS Coventry and Warwickshire ICB (APE0025), NHS Dorset Integrated Care (APE0027)
328 NHS Coventry and Warwickshire ICB (APE0025)
329 NHS Dorset Integrated Care (APE0027)
330 NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Frimley Integrated Care (APE0020), NHS Northamptonshire ICB (APE0023), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
331 NHS Suffolk and North East Essex ICB (APE0010)
332 NHS Black Country ICB (APE0014)
333 The Pharmacists' Defence Association (APE0030)
334 Royal Pharmaceutical Society (APE0038)

> *"We are desperate for electronic prescribing and we know the benefits that it can offer across integration within the hospital and everything. But it's the IT, digital enablers that are holding us back. And it's not for want of wanting to do it but having the IT resource and support and the digital enablers is what is our stumbling block."*[335]

One of the attendees at our roundtables stated that the Trust they worked in had fully electronic prescribing, but acknowledged the significant effort and investment that has made it possible:

> *"I kind of feel like I'm the elephant in the room in my Trust, as we have been fully electronic for EP [electronic prescribing] for over 20 years and were a global digital exemplar trust. And as a result of that, on our two main hospitals, well actually in all our hospitals, we're fully electronic for everything, notes, everything. I'm not saying that because I want to say it is possible, but rather it's taken 20 years of hard work and investment for our trust to get to the point that it is now. We also required the Global Digital Exemplar fund in order to get to where we are now."*[336]

A roundtable participant who works in homecare stated:

> *"So we have 116,000 paper prescriptions flying around the system in the post in the homecare world every month. We are absolutely not on track for electronic prescribing within homecare because it is very difficult to actually get a legally valid prescription from a hospital out into either a community pharmacy or out to a homecare provider, who are in effect community pharmacies. And at the moment one of the barriers that we have is being able to get that electronic prescription with an advanced electronic signature to have an order number and a clinical validation before it leaves the hospital. So, we are definitely not on track for our half a million plus homecare patients."*[337]

The Department's submission states that the commitment is on track to be met, and points to work done by the NHSE Transformation Directorate, which holds central responsibility in "levelling up digital maturity" ensuring NHSE Trusts are meeting core standards (which includes EPMA). The submission states that a "Digital Maturity Assessment" is currently being carried out, but initial data from it suggests that:

> *"~ 20% of providers have a high proportion of paper-only prescriptions,*
>
> *at least 80% of providers have some form of electronic prescribing – varying degrees of maturity but on the journey to meet the 2024 commitment,*
>
> *~ 20% of providers have up to 80% of services with all parts of the medicines process electronically, and*
>
> *3% have achieved the commitment of e-prescribing across all appropriate NHS services with sophisticated systems."*

335 Stakeholder roundtable
336 Stakeholder roundtables
337 Stakeholder roundtables

The Department's submission also acknowledges that there would have been a delay in implementing EPMA in some Trusts due to Covid-19, as their focus has been on recovery following pandemic conditions. Therefore, the submission concludes, the deadline for this commitment has been pushed to 2025.[338] However, interestingly, the Department's supplementary evidence states:

> *"This target will be met in hospitals by 2026 (as per trajectory of the FD programme). The paper prescribing target is not inclusive of all care settings where prescribing occurs for example dispensing doctors, dentistry, optometry."*[339]

In conclusion, the evidence we have received from stakeholders indicates that this target will not be achieved by 2024. The Department has advised that the target timescale has been pushed back from 2024 to 2026. The Departments submission shows that only 3% of Trusts have achieved the commitment. The current rate of progress and the variable digital maturity of Trusts means that it is unlikely that the 2026 commitment will be met. We therefore conclude that the Government's progress on meeting this commitment is inadequate.

Was the commitment effectively funded (or resourced)? Rating: Requires Improvement

NHS Northamptonshire ICB and NHS Dorset Integrated Care stated that, in their experience, the commitment has been effectively funded.[340] However, most of the written evidence submissions which addressed this point do not think the funding model allows for effective and consistent delivery and effectiveness. NHS Black Country ICB stated that funding for new EPMA systems requires Trusts to "fund match" which excluded some Trusts who are not in a financial position to do so, from applying.[341] The RPS argued that because of the need to find matched funding, Trusts, when choosing which EPMA model to buy, are limited to choosing one they can afford rather than selecting the system with the functionality best suited to them and the services they provide. According to the RPS:

> *"The funding is only partially covering the commitment required, this is due to limitations of funding available and understanding within the Trust of the resource requirement to achieve the project and business as usual demands and the optimisation requirements to keep the system and operational processes developed to meet the benefits planned."*[342]

Omnicell, a provider of EPMA systems stated in their submission that:

> *"Based on our discussions with customers and key opinion leaders, funding has not been adequate because the original scope did not go far enough, i.e., no funding earmarked for closed loop solutions in the form of automated medicine cabinets."*[343]

338 Department of Health and Social Care (APE0039)
339 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
340 NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027)
341 NHS Black Country ICB (APE0014)
342 Royal Pharmaceutical Society (APE0038)
343 Omnicell (APE0028)

The Department's submission pointed to funding for this commitment being made available through various national programmes and acknowledged that it is difficult to estimate the total amount allocated due to it being a mix of national and local funding. The Department's submission concedes that most of the funding has been focused on supporting the costs of IT systems:

> *"Dedicated funding has not been provided for digital teams within NHS Trusts to support the implementation and on-going deployment and optimisation of e-prescribing systems."*[344]

In their additional written evidence, the Department set out that £73,462,000 was distributed by March 2021 between 68 NHS Trusts for EPMA Pharmacy Infrastructure, stating that the funding has "shifted the coverage of EPMA in NHS trusts from 19% in 2018 to 70%".[345] There are 213 Trusts (including ambulance Trusts) in England,[346] meaning that about 32% of Trusts received funding for the EPMA Pharmacy Infrastructure. Furthermore, the submission outlines the distribution of this funding, in three phases:

> *"Phase 1 2018/19 – 13 Trusts - £16.2m*
>
> *Phase 2 2019/20 – 28 Trusts - £29.4m*
>
> *Phase 3 2020/21 – 27 Trusts - £27.9m."*[347]

In addition to this, the Department's additional evidence states:

> *"The funding allocation to introduce EPMA into hospitals has been costed as part of delivering the core standards for hospitals to have EPRs. This is being administered through the Frontline Digitisation Programme, as part of levelling up digital maturity."*[348]

The funding made available for this commitment has not enabled all Trusts to eliminate paper prescribing, which to a large part seems to be due to inequity in financial support to achieve digital maturity across the board. The extra funding for EPMA Pharmacy Infrastructure only covers a third of Trusts in England. The digital infrastructure to support the roll-out of this commitment is not in place, which the evidence suggests is due to lack of investment. Therefore, we conclude that the funding aspect for this commitment requires improvement.

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Requires Improvement

The submissions we received were largely encouraging regarding the possible positive impact of eliminating paper prescribing, including increasing efficiency and safety.

Some submissions also pointed to risks. One of the risks identified by the British Oncology Pharmacy Association (BOPA) was availability of appropriately trained staff. BOPA stated

344 Department of Health and Social Care (APE0039)
345 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
346 NHS Digital, NHS Workforce Statistics - March 2023 (Including selected provisional statistics for April 2023), 29 June 2023
347 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
348 Supplementary evidence provided by the Department of Health and Social Care (APE0041)

that oncology services are "far ahead of broader NHS services with regards to digital prescribing", and that NHSE's service specification for prescription of chemotherapy, also called Systemic Anti-Cancer Therapy (SACT),[349] services requires SACT prescriptions to be made through EPMA. However, BOPA argues that introducing EPMA is not a guarantee for safety:

> *"Although ePMA systems are known to improve the safety of SACT prescribing their introduction does not eliminate prescribing errors and may introduce their own specific risks. The UK SACT board has recently published updated standards for the safer use of ePMA systems. Key to the ability to meet these standards is the availability of appropriately trained staff (who are generally pharmacist and pharmacy technicians) and whilst enhancing digital skills are a focus of the NHS the lack of oncology pharmacists and pharmacy technicians NHS wide is a threat to providing robust and quality assured ePMA systems."*[350]

Other stakeholders pointed to electronic prescribing not being suited to some patients. Professor Maidment from Aston University, argued that digital prescribing must be carefully introduced to ensure that digital exclusion does not cause a "significant issue" to groups who are digitally excluded, such as some older people.[351] NHS Black Country ICB concluded that "EPMA systems have varying functionality and are not suitable for all patient groups".[352] The RPS acknowledges the "well documented" proven benefits to patients and staff but stated that:

> *"[…] with digital systems there are unintended consequences which can have detrimental effects, such as alert fatigue which can result in errors, more time is needed to manipulate the system to complete tasks, there is a greater cognitive burden to completing tasks digitally rather than on paper and changes to communication flow between staff and patients."*[353]

NHS Bedfordshire, Luton and Milton Keynes ICB similarly stated:

> *"Overall, we believe this would enhance medicines safety, reducing [errors], and improving communication between healthcare providers across our ICS. That said, we must consider the unintended consequences towards achieving this and impact on those who are not digitally enabled (both patients and different healthcare settings."*[354]

Omnicell agreed it will have a positive impact on patients and people in receipt of social care, but stated:

> *"[…] any outcomes need to be carefully understood when looking at impact on workload and potential increase in errors elsewhere. To give an analogy, it is similar to designing a new car engine to make it go faster but failing to consider the impact on the gearbox, clutch and braking system which will inevitably impact safety."*[355]

349 Macmillan, What is Chemotherapy?, accessed 130623
350 British Oncology Pharmacy Association (APE0021)
351 Professor Ian Maidment, Aston University (APE0004)
352 NHS Black Country ICB (APE0014)
353 Royal Pharmaceutical Society (APE0038)
354 NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
355 Omnicell (APE0028)

Participants in our stakeholder roundtables were generally positive about the benefits of electronic prescribing, and many pointed to increased safety due to fewer errors and enhanced monitoring of prescriptions.[356]

The Department's submission pointed to a series of reports which outline the learning from implementation of e-prescribing systems and its benefits, particularly in relation to reduction of medication related errors. However, the response concludes that:

> *"Due to the medium to long term nature of the commitment, there has not yet been full benefit realisation commission, however this commitment is in progress and is currently on track to be met."*[357]

Based on the evidence we have received, we are not convinced that the possible risks have been fully considered by the Government, nor mitigated for. We conclude that the commitment's aim of eliminating paper prescribing may impact negatively on some patient groups. At the same time, we believe that the benefits for patients could be better realised and described. We therefore rate the impact of this commitment on patients and people in receipt of social care as 'requires improvement'.

Was it an appropriate commitment? Rating: Inadequate

Whilst most submissions addressing this point are clear on the advantages of digital prescribing,[358] there are also concerns as to implementation and potential adverse impacts on some patient groups of eliminating paper prescribing. Community Pharmacy Lincolnshire stated that digital prescribing is "vital across the system" in order to efficiently manage the integration of primary and secondary care services, and to maximise the benefit of other initiatives, such as the DMS.[359] NHS Frimley Integrated Care stated that the roll-out of digital prescribing could improve patient safety and streamline services, but stated that:

> *"This commitment needs to encompass rapid deployment of EPS into secondary care which has been requested for many years but following some small scale pilot work a few years ago doesn't seem to have progressed significantly. Also with regard to EPR/EHR [electronic patient record/ecltronic health record] systems, interoperability of these systems and interfacing with other existing clinical systems needs to be a default standard that vendors need to meet to avoid building costly new information silos between parts of the NHS."*[360]

Omnicell were less positive about the potential of this commitment:

> *"The commitment itself is problematic as it does not focus on the entire patient journey across the NHS. Electronic prescribing is one key element of how a patient receives medication in the NHS. Taken in isolation it fails to address the delivery route of medicines to the patient. At the same time the NHS is tasked with adopting closed loop medicines administration, adopt*

356 Stakeholder roundtables
357 Department of Health and Social Care (APE0039)
358 NHS Black Country ICB (APE0014), NHS Frimley Integrated Care (APE0020), Community Pharmacy Lincolnshire (APE0022), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)
359 Community Pharmacy Lincolnshire (APE0022)
360 NHS Frimley Integrated Care (APE0020)

> *GS1 and adopt DM&D standards. There are multiple providers working in the NHS with different workflows and working to different data standards, meaning the opportunity for standardisation has been missed. If reflect on the patient journey then whilst the prescription now may be electronic the process of supplying, picking and administering is still manual and fraught with risk due to human error, waste and inefficiencies."*[361]

During our roundtables some of the participants expressed concerns about the commitment unintentionally leaving some patients groups behind due to being less digitally literate. One participant argued that some people living with disabilities needed to be better accommodated with the tools they need to access digital solutions, before it is rolled out more widely across the NHS:

> *"[…] for people with Parkinson's like myself, who have a pronounced tremor, operating computers can be very difficult and there is a growing sense in the Parkinson's community here that we could be left behind in the progress made towards digital services and prescriptions. And that digital isolation adds to the isolation that we can already feel when face-to-face services aren't working properly. So yes, I've experienced those issues both in hospital and in the community, so it's a tricky one to solve. But I think before there is a total switch to digital that there needs to be better interactive controls for people with disabilities. So a voice control for instance, but many voice control systems don't recognise the duller, or lack of, pitch in people's voices when they have Parkinson's."*[362]

The Department's response does not explicitly refer to the appropriateness of the commitment but emphasises the positive impact on patients and people in receipt of social care, as well as for pharmacies, through increased efficiency, a reduction in medication related errors and through improved patient care.[363] In the supplementary evidence submitted by the Department, there is a slight ambiguity in what this commitment is considered to cover. The additional evidence states that:

> *"Digital prescribing is also known as "e-prescribing". The definition that is assumed for ePrescribing is the one that was utilised by NHS Connecting for Health, namely: "the utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration, and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process"."*[364]

However, the Department's additional evidence also states:

> *"The paper prescribing target is not inclusive of all care settings where prescribing occurs for example dispensing doctors, dentistry, optometry."*[365]

361 Omnicell (APE0028)
362 Stakeholder roundtables
363 Department of Health and Social Care (APE0039)
364 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
365 Supplementary evidence provided by the Department of Health and Social Care (APE0041)

We rated the appropriateness of the commitment as 'inadequate'. This is because although fulfilment of the commitment will have a positive impact on many people, it is not clear that eliminating paper prescribing for all groups of patients and people in receipt of social care is appropriate, or that the risks of doing so have been adequately considered. In the Department's additional evidence, this seems to be acknowledged, as the submission points to a few care settings where elimination of paper prescribing will not be "the target". Although this is an understandable reversal in target, this contradicts what was set out in the original commitment. It is also not clear whether this change in target represents an understanding from the Department that the care settings to be excluded from the commitment are those in which vulnerable or digitally excluded patients and people in receipt in social care are likely to be the main patient group. As the Department sets out in its submission, the deadline for the commitment will not be met. We consider that the deadline was not appropriate, and was overly ambitious in the context of an NHS digital infrastructure which has not been enabled to, and is not ready for, this radical change across the board.

Commitment 2: Aseptic services

Overall Commitment Rating and Overview of aseptic services: Requires Improvement

This commitment comes out of the recommendations made in the 2020 review of the quality, safety and resilience of the hospital-pharmacy aseptic service commissioned by the Government, led by Lord Carter of Coles (the Carter review). The Carter review, titled 'Transforming NHS pharmacy aseptic services in England', described aseptic services as follows:

> *"NHS Pharmacy aseptic services in England provide sterile controlled environments for the preparation of injectable medicines into ready-to-administer (RtA) formats for patients. Although not highly visible to patients, £3.84 billion is spent on injectable medicines across the NHS in England each year. Services are subject to high levels of regulatory control and quality assurance. Products include chemotherapy, injectable nutrition and clinical trials for new medicines."*[366]

In the foreword to the review, Lord Carter stated that delivering better aseptic services enables the delivery of better clinical outcomes, better patient experience and productivity gains in product costs, clinical staff time and in-patient bed days. The Review made 17 recommendations, including one to consolidate services into new hub and spoke services[367] to scale up aseptic services capacity from 3.4 million individual doses a year to over 40 million. This, the review suggested, would free up 4,000 whole time equivalent nursing staff, which in turn would have a positive impact on reducing issues in staff vacancies. To achieve this, the review recommended developing a small number of regional hubs across England which could be either NHS, commercial, or joint ventures. The review concluded that this would result in the creation of industrialised automated facilities, required to increase capacity by the 10-fold required.[368]

366 DHSC, Transforming NHS pharmacy aseptic services in England (October 2020)

367 Note: Hub and spoke dispensing can be summarised as community pharmacies ("the spokes") outsourcing elements of the dispensing procedure to other pharmacies ("the hubs").

368 DHSC, Transforming NHS pharmacy aseptic services in England (October 2020)

In reviewing the evidence available to us, and the Government's response to our evaluation, it is clear that the commitment is still some way off from being met. We have approached this commitment focusing mainly on the evidence around delivering the aseptic hubs, rather than the other initiatives referred to in the Department's response. The hub and spoke model project is currently in its pilot phase, which means that data on progress and impact is extremely limited, and we have therefore considered the commitment in progress so far achieved as well as the potential should it be fully met after transitioning out of the pilot phase. In conclusion, our overall rating for this commitment is that it requires improvement. This chapter will set out our reasoning for this rating in more detail.

Was the commitment met overall (or on track)? Rating: Inadequate

The majority of submissions did not agree that the commitment was met or on track to be met.[369] NHS Black Country ICB characterised the barriers to meeting this commitment and emphasised the need to work at pace, but being restricted by skills and workforce shortages and "prohibitive legislative requirements". In addition to this, they point to an "aging estate and lack of modernisation" impacting delivery alongside "reduced industry capacity and partnership".[370] BOPA stated that demand is outstripping ability to supply safe services, which they argue manifests in delayed treatment and "on-going concerns that this is a service approaching a crisis point".[371] The PDA similarly stated that:

> *"There is a need to adapt aseptic service more rapidly, and there is an increase in aseptically prepared products which are scaling up faster than services can evolve."*[372]

During our roundtables many participants who work in hospital argued that the lack of workforce with the specific training and education to carry out the work in aseptic hubs was seen as a barrier to success.[373] The RPS stated that the commitment is not yet met but that it is on track to be. However, they also expressed concerns regarding the workforce needed to support this commitment:

> *"Additionally, the changes in the pharmacy undergraduate degree course and pharmacy technician course have contributed to a severe shortage in the technical service workforce. At present there is no clarity on how the workforce shortage will be addressed. Utilisation and technical training of pharmaceutical scientists and other groups must be considered as a priority to ensure Hubs have capacity."*[374]

Regarding ensuring there is a skilled workforce to realise this commitment, the Department's additional evidence sets out that a "workforce workstream" has been established to "implement the workforce recommendations from the national review", pointing to a national level working group which is doing wider work regarding workforce. The additional evidence also states that a call for evidence has been issued, aimed at identifying:

369 NHS Surrey Heartlands ICB (APE0006), NHS Black Country ICB (APE0014), British Oncology Pharmacy Association (APE0021), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027)
370 NHS Black Country ICB (APE0014)
371 British Oncology Pharmacy Association (APE0021)
372 The Pharmacists' Defence Association (APE0030)
373 Stakeholder roundtables
374 Royal Pharmaceutical Society (APE0038)

> *"[…] existing good practice and innovation in development of the aseptic service workforce. Returns will feed into national developments."*[375]

However, this work does not appear to have a deadline for achieving the intended outcomes, nor is there a reference to funding being made available to grow and/or develop the workforce. The Department submission states that the commitment has been partly met and remains in progress. The commitment is currently in a pilot phase, where it has been rolled out across 5 pilot sites.[376] In the Department's additional evidence, the following is set out:

> *"We will use the following measures to evaluate the impact of the aseptic hubs:*
>
> - *Increase in NHS aseptic production capacity by product type — chemotherapy, parenteral nutrition, antibiotics, monoclonal antibodies, clinical trials (through releasing capacity in spokes*
> - *Uptake by trusts of standardised, bulk-produced aseptic medicines (by product type) produced by NHS hubs and commercial suppliers*
> - *Nursing time saved across trusts within the hubs' supply geography*
> - *Increase in capacity for out of hospital intravenous therapy, e.g. parenteral nutrition through homecare, outpatient antimicrobial therapy, other infusion clinic and homecare capacity*
>
> *Hubs are not expected to be fully operational until 2026/27, so there is limited ability to evaluate their impact before then. However progress against project milestones as the hubs develop will be tracked through the programme board."*[377]

We conclude, based on the evidence provided to us, that the commitment is unlikely to be met due to a combination of practical challenges, including workforce gaps. Although the Department provided detail on work being done to prepare the workforce for this, we consider that introducing the pilots before there are adequate arrangements to provide a sufficient and trained workforce to run them, is putting the cart before the horse. We therefore find that the Government progress on the commitment overall is inadequate.

Was the commitment effectively funded (or resourced)? Rating: Requires Improvement

The Department's submission sets out that the Department made a bid for £275 million to the Treasury to implement the Government's vision for the hub and spoke model, of which £75 million was awarded to fund "a small number of pathfinder hubs (with supporting workstreams) to develop a proof of concept and track whether the anticipated benefits materialise". The Department intends to submit a further capital bid in the 2026/27 Spending Review to support the funding of additional hubs for full national roll out, which the Government estimates will cost £275 million.[378]

375 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
376 Department of Health and Social Care (APE0039)
377 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
378 Department of Health and Social Care (APE0039)

The Department's response did not include any detail on the pilots, budgets allocated, or a plan or method for evaluating its success. Reports from South Tyneside and Sutherland NHS Trust, and West Yorkshire Association of Acute Trusts suggested there has been capital funding for two hubs in those Trusts.[379] According to the news story from South Tyneside and Sutherland:

> *"£29.7 million of national NHS funding has been secured. It will be used to create a new state-of-the-art sterile drug manufacturing hub to serve all eight hospital and community NHS Foundation Trusts in the region."*[380]

West Yorkshire Association of Acute Trusts website stated that £24 million of capital funding to create an aseptic hub facility in the region, which is part of the £75 million being made available by NHSE to hospitals over the next three years to create aseptic hub sites to increase production and capacity within aseptic services in England.[381]

All other submission addressing this question state that they have not had any funding to implement this commitment.[382]

At this stage in the pilot phase, and with the information available to us, it is unclear whether this model is viable and funding levels adequate, or whether the estimated further £275m that will in the future be requested will prove sufficient. We therefore conclude that the processes regarding the funding of this commitment requires improvement.

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Good

The submissions addressing this point generally recognise the likely positive impact of, and need for, improved aseptic services.[383] Some of the submissions state that it is not possible to conclude that there has been a positive impact on patients and people in receipt of social care, as the commitment is still in progress and funding only rolled out at a small number of sites.[384] NHS Frimley Integrated Care commented on the potential positive impact of the commitment if rolled out past its pilot stage, and states it could help to ensure that patients will receive "high-quality aseptic services, reduce waste, and improve efficiency".[385] Omnicell and the RPS are similarly positive regarding the impact if implemented.[386]

BOPA commented on the state of aseptic services more widely, stating that:

> *"Aseptic services including those pertaining to provision of SACT is at crisis point and at risk of impacting quality of care and patient safety. Reliance on*

379 South Tyneside and Sunderland NHS Foundation Trust, "£29.7 million cash 'injection' to secure drug manufacturing in region's NHS for next 20 years", 17 November 2022; West Yorkshire Association of Acute Trusts "Capital investment to create an aseptic hub facility for West Yorkshire Association of Acute Trusts", 21 June 2022

380 South Tyneside and Sunderland NHS Foundation Trust, "£29.7 million cash 'injection' to secure drug manufacturing in region's NHS for next 20 years", 17 November 2022

381 West Yorkshire Association of Acute Trusts "Capital investment to create an aseptic hub facility for West Yorkshire Association of Acute Trusts", 21 June 2022

382 NHS Surrey Heartlands ICB (APE0006), NHS Black Country ICB (APE0014), NHS Dorset Integrated Care (APE0027), Omnicell (APE0028), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

383 NHS Surrey Heartlands ICB (APE0006), NHS Frimley Integrated Care (APE0020), NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

384 NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS Frimley Integrated Care (APE0020)

385 NHS Frimley Integrated Care (APE0020)

386 Omnicell (APE0028), Royal Pharmaceutical Society (APE0038), NHS Black Country ICB (APE0014)

> *third party providers leaves the NHS in a vulnerable position should one or more of the limited number of providers choose to leave this market. […] There is a very real danger that we will not be able to meet the needs of our patients for treatment as a result of insufficient aseptic compounding capacity."*[387]

Referencing various recommendations made in the DHSC commissioned report 'Transforming Pharmacy Aseptic Services in England', the Department's submission points to projects which would achieve a positive impact for patients and people in receipt of social care. These includes the possibility to release staff currently dedicating time to the more manual model of delivery of these services to do other tasks, and to treat patients. Other benefits emphasised in the Department's response include better error tracking, allowing patients to access outpatient antimicrobial therapies closer to home, improving patient safety and experience and improving staff productivity.[388]

As we set out the start of this section of the report, due to the limited data and evidence available on this commitment, we have employed a mixed approach in assessing this commitment, partly looking at the potential of the commitment and partly the actual achievements made. In respect of the impact on patients and people in receipt of care, we have focused on the potential of the commitment as even the pilot phase of this commitment is at an early stage and no measurable impact evaluation exists. We agree that the impact this commitment could have if realised, is likely to be positive for patients and people in receipt of social care. We therefore rate this aspect of the commitment as 'good'.

Was it an appropriate commitment? Rating: Requires Improvement

Most submissions were generally positive regarding the potential for this commitment to deliver improvements to patient care and safety. NHS Dorset Integrated Care however pointed out:

> *"Automation isn't the saving grace. Still need Pharmacists in the current model and the workforce challenges locally are a continuing issue."*[389]

Although complimentary regarding the commitment's appropriateness, Omnicell stated that the commitment is too specific, which they argue "hasn't allowed for wider innovation in process and efficiency".[390] The RPS similarly criticised the commitment, stating that the strategy to deliver the commitment "does not go far enough".[391] The Department's submission refers to the 'Transforming NHS pharmacy aseptic services in England' report, and to the various possible benefits to patient care and staff productivity.[392]

We consider the aim of the commitment to be wholly appropriate, however we are not fully satisfied with the detail included in it. Based on the evidence we have received, it seems that, despite staff productivity being cited as a possible benefit of this approach, little consideration has been given to the staff operation in relation to these hubs. As we

387 British Oncology Pharmacy Association (APE0021)
388 Department of Health and Social Care (APE0039)
389 NHS Dorset Integrated Care (APE0027)
390 Omnicell (APE0028)
391 Royal Pharmaceutical Society (APE0038)
392 Department of Health and Social Care (APE0039)

highlighted in our report on the health and social care workforce,[393] as have countless others in reports and reviews, the Government is not currently delivering on its commitments made regarding its workforce. We are encouraged by the plans set out in the NHS Long Term Workforce Plan but we are also concerned about the urgency with which this issue needs to be addressed which it is unlikely to be achieved through the Workforce Plan, which is focused on long term changes.[394] We consider that this commitment is specifically reliant on the workforce (as well as secure capital funding). We therefore conclude that the appropriateness of the commitment requires improvement, remaining concerned that issues in workforce, digital infrastructure and funding may pose specific challenges in realising this commitment.

393 Third Special Report of the Health and Social Care Committee, Evaluation of Government's commitments in the area of the health and social care workforce in England HC 112

394 NHSE, NHS Workforce Long Term Plan, June 2023

4 Workforce education and training

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists.	Requires improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists.	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

In this section we provide an assessment of Government commitments in relation to the pharmacy workforce and its education and training. Two commitments were selected for evaluation:

"A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists."

"Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists."

The commitments were set out in the correspondence sent to the Panel by the Department in response to a request for recent commitments made regarding pharmacy.[395]

The first commitment was initially set out within the Year 3 of the CPCF (2021 to 2022), published in August 2021.[396] This commitment is set out in a section titled 'Training

395 Correspondence from the Parliamentary Under Secretary of State for Primary Care and Public Health on the Expert Panel's Independent Evaluation in the Area of Pharmacy (3 April 2023)

396 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021

and Development' of the Year 3 of the CPCF (2021 to 2022). The document sets out that Government is committed to ensure that clinical skills within pharmacy teams are better utilised, and that the Government will work to ensure employers can enable employees to undertake further professional development. The commitment highlights independent prescribing training for existing pharmacists as something which will be included in that increased training offering.[397] The General Pharmaceutical Council (GPhC) defines a pharmacist independent prescriber as someone who "may prescribe autonomously for any condition within their clinical competence". This clinical competence currently excludes three controlled drugs (for treatment of addiction).[398]

The second commitment is based on a longer commitment set out in CPCF 5-year deal: year 3 (2021 to 2022), published in August 2021. The commitment appears in the section on regulatory reform, in which the Government also set out to amend regulations governing the operation of pharmacies in the pandemic, and the way in which pharmacies are run and the tasks they carry out. This commitment focuses on ensuring skills in pharmacies are better integrated in the services provided.[399] The PCN and community pharmacy workforce in England comprises registered pharmacists, registered pharmacy technicians (both registered with the GPhC) and pharmacy assistants. Pharmacy professionals work in community pharmacies, in hospitals as part of specialist teams, and deliver clinical services within multidisciplinary teams across PCNs.[400]

Commitment 1: A programme for PCN and community pharmacy professionals

Overall Commitment Rating and Overview a programme for PCN and community pharmacy professionals: Requires Improvement

This commitment sets out the Government's aspiration to offer a "further" 3-year education programme but provides little detail what this will entail other than the independent prescribing training for "existing pharmacists". The Department's submission points to an "initial timescale" of three years starting in April 2021 and running to 31 March 2024.[401] The commitment makes reference to pharmacy professionals working in PCNs as well as community pharmacies and builds on the stated aims of the PhIF launched in 2016. The purpose of the PhIF was to accelerate the integration of pharmacy professionals across health and care systems.[402] The PhIF included the following education and training pledges:

- *"Commissioning of Health Education England to produce a new workforce plan for pharmacy professionals in primary care;*
- *A prescribing qualification for pharmacists working in care homes and urgent care;*

397 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021
398 General Pharmaceutical Council, "Pharmacist independent prescriber" accessed 020523
399 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022), August 2021
400 The King's Fund, A vision for pharmacy practice in England: A rapid review of the policy context (2016–22) (June 2022)
401 Department of Health and Social Care (APE0039)
402 NHS England "Pharmacy Integration Programme", accessed 040523

- *Grants for community pharmacists to access postgraduate clinical pharmacy education and training courses up to diploma level;*

- *A programme of pharmacy technician clinical leadership development."*[403]

After completing their foundation training, a pharmacist seeking to become an independent prescriber must complete at least 90 hours of supervised practice specifically related to prescribing by a DPP.[404] The 2021 Community Pharmacy Workforce Survey carried out by Health Education England (HEE) identified 1,154 independent prescriber pharmacists filling 933 FTE (full-time equivalent) roles, which translates to one independent prescriber per 10 community pharmacies. HEE states that this is the same, in proportionate terms, as in 2017. London had considerably more independent prescribers compared to other regions. Approximately a quarter of all qualified independent prescribers were carrying out independent prescribing.[405] In February 2023 the Pharmaceutical Journal warned of a shortage of DPPs to support the expansion of training, referring to experts who stated that this was particularly an issue in community pharmacy.[406]

In March 2023 HEE National Pharmacy Programme issued a £500,000 tender for a one-year contract, commencing in July 2023, to develop and deliver training to pharmacist and pharmacy technicians across England from community pharmacy backgrounds to ensure that Designated Supervisors (DS) and DPPs are trained, competent, and confident to provide support to trainees.[407]

Although there are encouraging signs that the commitment is on track to be met, there are significant challenges for the commitment to deliver what the Government set out for it to do. As we highlighted in our report on the health and social care workforce,[408] the successful training and development programs relies on there being funding and capacity within an organisation to back-fill and cover for colleagues undertaking the training. Based on the evidence we have received this seems to be a particularly significant problem in community pharmacy, where the lack of staff to cover training absences and the capacity in terms of staff time to provide supervision is a particular issue due to their small size. The increased training provision for independent prescribers has also highlighted the specific issues of retention in community pharmacy, as many pharmacists leave community pharmacies for work in PCNs once they have their independent prescribing qualification. The disparity between what community pharmacies, and PCNs supported by ARRS funding, can pay pharmacy professionals as well as the working conditions they can provide, is benefitting PCNs at the expense of community pharmacies. Overall, we agree the aim to upskill staff is appropriate, but remain concerned about the barriers to success, and possibly also, the unintended consequences of the commitment. We have therefore rated the overall commitment as requires improvement.

403 NHSE, "Pharmacy Integration Fund of £42 million announced", 20 October 2016
404 General Pharmaceutical Council, FAQ: reforms to the initial education and training of pharmacists, accessed 020523
405 Health Education England, Community Pharmacy Workforce Survey 2021 (January 2022)
406 The Pharmaceutical Journal "Help wanted: mentor shortage for potential prescribers" accessed 020523
407 Contracts Finder, "Education Supervisor Training for the Community Pharmacy Workforce" accessed 020523.
408 Third Special Report of the Health and Social Care Committee, Evaluation of Government's commitments in the area of the health and social care workforce in England HC 112

Was the commitment met overall (or on track)? Rating: Requires improvement

Evidence about whether the commitment was on track to be met was mixed. While many submissions we received acknowledged the availability of the training provision, especially the independent prescribing training.[409] Several submissions, however, pointed out that there were issues in accessing the required DPPs to carry out the training.[410] Many submissions also cited a lack of protected, and properly funded, learning time for those accessing the training.[411] During our roundtable with stakeholders, several participants pointed to the lack of DPPs as a barrier to rolling out independent prescribing training:

> *"Talking to one of the largest multiples recently about this, their national training development manager has got hundreds of pharmacists who would like to do IP training. But he said he got access to about 40 DPPs. So the sums just don't add up."*[412]

NHS Nottingham and Nottinghamshire ICB questioned what the available training offer for pharmacy technicians actually consists of, and criticised the central co-ordination of training for the pharmacy workforce:

> *"The Pharmacy Workforce does not have a dedicated well-funded training and education team that co-ordinates training and provides peer support and mentorship. This means that pharmacy staff have to incorporate training others into their day job which puts pressure on the whole system. We need a system similar to that of our medical and nursing colleagues."*[413]

NHS Suffolk and North East Essex ICB and Pharmacy2U stated that the workforce numbers are too low, and therefore the workforce too stretched for this commitment to be met.[414] The NPA's Women Member's Forum stated that:

> *"[…] education and training of pharmacy teams is difficult to achieve in the current climate with stress levels at an all-time high and morale at its lowest."*[415]

The Department's submission concludes that this commitment is on track to be met. Although the initial timescale for this commitment is the three years from April 2021 to the end of March 2024, the Department concedes that the full analysis of the training programme won't be available until late 2024. The submission acknowledges the demand for training, and that this in the case of pharmacy technicians "exceeds the supply". In the submission the Department also states that:

> *"Generally, the commitment has been received positively, with community pharmacy supportive in principle of the training programmes. However, challenges around supporting staff development against concerns around*

409 NHS Surrey Heartlands ICB (APE0006), Pharmaceutical Services Negotiating Committee (APE0009), The Company Chemists' Association (CCA) (APE0018), NHS Sussex Integrated Care (APE0037)
410 Avon LPC (APE0017), NHS Coventry and Warwickshire ICB (APE0025)
411 Pharmaceutical Services Negotiating Committee (APE0009), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), British Oncology Pharmacy Association (APE0021), The Community Pharmacy Humber LPC (APE0032)
412 Stakeholder roundtables
413 NHS Nottingham and Nottinghamshire ICB (APE0013)
414 NHS Suffolk and North East Essex ICB (APE0010), Pharmacy2U (APE0015)
415 The NPA Women Members' Forum (APE0031)

> *pharmacy closures demonstrate the backdrop to conversations. Multiple discussions centre around the need for backfill or dedicated time for pharmacy staff to support development/training that aligns to the GP model. For example, significant challenges around backfill, and designated prescribing practitioner (DPP) training support have been highlighted."*[416]

In their supplementary written evidence, the Department set out Planning for the 2025–2026 Foundation Programme which includes a recommendation of a "rotational placement". This the Department concludes, can provide "additional capacity for DPP provision for students", and argues may be "particularly beneficial for those based in community pharmacy".[417]

Training and development for the pharmacy workforce is being offered in some places, especially to pharmacists. However, worryingly, we were unclear what the offer was for other pharmacy professionals. This commitment is made regarding pharmacy professionals in primary care and community pharmacy, and whilst there for example has been funding for training of pharmacy technicians in ARRS roles, this has not been the same for pharmacy technicians in community pharmacy. There are also significant challenges in ensuring that organisations are able to take up the offer to undertake the training. This includes the current high demand for DPPs to supervise training, and high pressure on services leaving little time to dedicate to training and development. We therefore conclude that in regards to whether this commitment is met or on track to be met, Government progress 'requires improvement'.

Was the commitment effectively funded (or resourced)? Rating: Requires Improvement

Several submissions agree that funding for courses is positive, however a common barrier to getting staff into training is that providers cannot afford to send people on training without funding to cover their tasks while they're away.[418] One of the participants at our roundtable told us:

> *"[…] we're wanting the profession to upskill in this area on top of their day-to-day jobs and without the safeguards, the provision for learning, the support for learning, in place. And I guess colleagues would say there's no funding for that, there's no infrastructure for that currently in place."*[419]

The PDA and the RPS also point to the busy schedule of pharmacies due to delivering a range of services, and therefore the challenge in fitting in learning and development time.[420]

416 Department of Health and Social Care (APE0039)
417 Supplementary evidence provided by the Department of Health and Social Care (APE0041)
418 Pharmaceutical Services Negotiating Committee (APE0009), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), Community Pharmacy Lincolnshire (APE0022), The NPA Women Members' Forum (APE0031)
419 Stakeholder roundtable
420 The Pharmacists' Defence Association (APE0030), Royal Pharmaceutical Society (APE0038)

Some submissions argue that a lack of funding for DPPs lead to less people being able to become prescribers as their training cannot be supervised.[421] NHS Surrey Heartlands ICB stated:

> *"The HEE fees were funded however the barrier, particularly for community pharmacists is access to a DPP (designated prescribing practitioner) so a funding contribution to support in providing backfill for the DPP's time would have prevented this being a barrier to community pharmacists."*[422]

NHS Dorset Integrated Care concluded that:

> *"Given the number of pharmacists in Dorset who would like to become IPs and the places/funding available it will be about 20 years before all current pharmacists can complete the necessary training."*[423]

In regards to providing support to help pharmacies backfill when a staff member is undertaking training, the Department's supplementary evidence stated that there is "no current budget allocated", but stated that there are "ongoing discussions on how best to facilitate DPP capacity". In addition to this, the Department's submission stated that:

> *"Education supervisor training is the process of being procured, subject to the successful procurement, will be available from September 23 to support individuals take on the role of DPPs. The funding allocated for this is £500,000 for 23–24 and the same amount is proposed for 24–25."*[424]

The CCA states that a knock-on effect of a lack of nationally commissioned independent prescribing services has in turn "acted as a significant barrier" to employers being able to invest in education and training.[425] Some submissions expressed concerns around ensuring training is prioritised and invested in, especially in community pharmacy.[426] NHS North East London ICB stated they had to use their own budget to fund this.[427] The Department's response acknowledges that training and development has not been a priority in community pharmacy during the Covid-19 pandemic, due to the "fundamental" role community pharmacies played in the response to it:

> *"As a result, education and training was deprioritised, and contributed to delays in starting the programme and completing procurement processes. It is anticipated that the final procurements will have commenced within the next couple of months. As a result of these delays, further evidence is being prepared for the affected commitments into 2024/25."*[428]

421 Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk and North East Essex ICB (APE0010), NHS Black Country ICB (APE0014), Avon LPC (APE0017), NHS Frimley Integrated Care (APE0020), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS Sussex Integrated Care (APE0037)

422 NHS Surrey Heartlands ICB (APE0006)

423 NHS Dorset Integrated Care (APE0027)

424 Supplementary evidence provided by the Department of Health and Social Care (APE0041)

425 The Company Chemists' Association (APE0018)

426 NHS Sussex Integrated Care (APE0037), HubRx Ltd (APE0011), Community Pharmacy Lincolnshire (APE0022)

427 NHS North East London ICB (APE0024)

428 Department of Health and Social Care (APE0039)

According to the NPA Women Member's Forum, there is a worry among community pharmacy owners that as soon as you invest, both financially, as well as in the time needed to train and supervise new members of staff, those who have been trained leave for other jobs, and hence the benefit to the organisation is never realised.[429] The PSNC stated:

> *"While the provision of funded education and training programmes to community pharmacists is to be welcomed, solely funding the cost of course fees does not address the wider cost for contractors of providing time during the working day for employees to undertaking the training. The provision of such 'protected learning time' or alternatively paying employees extra to recognise the training they undertake outside of their working hours is not a cost many contractors can currently afford, as a result of the NHS funding cuts they have suffered over several years."*[430]

The Department's submission states that funding for this commitment was set out in a memorandum of understanding (MoU) agreed between NHSE and HEE. This MoU outlined the "deliverables and financial envelope" available between 2021–2024 including £15.9 million in funding over three years. This funding model the submission argues, enables the eligible pharmacy workforce to apply for fully funded courses.[431] The Department's submission did not provide an overview of how much funding would be allocated to each group within the pharmacy workforce. In the Department's supplementary evidence, the Department points to work on post registration education and training modules for Pharmacy Technicians working in community pharmacy. The Department's submission states that the training programme is expected to be launched in "summer 2023", and £420,000 is expected to be invested in it in 2023/24. The submission states:

> *"The training programme is due to be launched in summer 2023 and will focus on 4 key areas:*
>
> - *Clinical Therapeutics and clinical assessment*
> - *Consultation and clinical decision making*
> - *Professional practice, including law and ethics and*
> - *Service improvement.*
>
> *The proposed Pharmacy Integration Programme workforce budget for 24–25 includes a 12- month extension of this contract. In addition, NHSE has recently updated service specifications for the Blood Pressure Checks and Smoking Cessation advanced services, to enable delivery by Pharmacy Technicians."*[432]

Almost all submissions addressing this commitment cited issues in sourcing funding to backfill staff absence for training or supervision, and a lack of funding for DPPs as the main barriers to benefiting from the commitment. Although the Department's supplementary evidence provided some detail on the training and development for pharmacy technicians, little attention seems to have been dedicated to ensuring there are

429 The NPA Women Members' Forum (APE0031)
430 Pharmaceutical Services Negotiating Committee (APE0009)
431 Department of Health and Social Care (APE0039)
432 Supplementary evidence provided by the Department of Health and Social Care (APE0041)

well resourced development opportunities for all pharmacy professionals. Other than the £420,000 pledged for pharmacy technician training no specific spending commitment had been made to a specific group within the pharmacy professional workforce. Based on the evidence available to us, we conclude that the funding aspect for this commitment 'requires improvement'.

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Requires Improvement

Many submissions agree that expanding prescribing capability is likely to have a positive impact on patients, as patients will have easier and quicker access to prescribed medicines.[433] However, some submissions pointed out that an unintended consequence of training community pharmacist in independent prescribing has been that many have left the community pharmacy sector for work in primary care, including PCNs, which have benefitted from extra funding for staff through the ARRS scheme.[434] The ARRS scheme funding also has wider effects on the community pharmacy workforce, including pharmacy technicians, who similarly leave the community pharmacy workforce for roles in primary care. The PSNC stated:

> *"Contractors report losing many staff members to new ARRS funded roles over the last few years, which alongside various impacts on working patterns brought about by the COVID-19 pandemic, have significantly contributed to the current workforce crisis which community pharmacy is suffering."*[435]

Some ICBs pointed to better access to training and upskilling in areas which have benefitted from ARRS funding encouraging some staff away from community pharmacy-based roles.[436] NHS Suffolk and North East Essex ICB stated:

> *"[…] the national drive to increase the pharmacy workforce in primary care working in PCNs has had a negative impact to community and hospital pharmacies across SNEE. Working toward the expectation of 5 to 6 clinical pharmacists per Primary Care Network (PCN) by 2023/24 and pharmacy technicians 1 to 2 per PCN, many of these have come from community and acute sectors."*[437]

During our roundtable, one of the participants told us about the practical impact on learning and development:

> *"In order to be able to be released to access free training or funded training places, you actually need to pay for a locum to come and backfill. So as an employer you might think, "Fair enough, I need to invest in my team to get them trained up", and so that's fine. The challenge you've got at the moment is there aren't any locum pharmacists. There are no pharmacists out there. We are experiencing a massive shortage of pharmacists and I'll*

433 NHS Surrey Heartlands ICB (APE0006), Pharmaceutical Services Negotiating Committee (APE0009), NHS Sussex Integrated Care (APE0037), British Oncology Pharmacy Association (APE0021)

434 Pharmaceutical Services Negotiating Committee (APE0009), Avon LPC (APE0017), NHS Leicester, Leicestershire and Rutland ICB (APE0033), The NPA Women Members' Forum (APE0031), Royal Pharmaceutical Society (APE0038)

435 Pharmaceutical Services Negotiating Committee (APE0009)

436 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Leicester, Leicestershire and Rutland ICB (APE0033)

437 NHS Suffolk and North East Essex ICB (APE0010)

> *give you the reason why: because of the ARRS funding scheme. So back in 2019 £3.4 billion was put aside to fund 26,000 healthcare professionals in PCNs. Since that time, about 6,500 full-time equivalent pharmacists have been taken out of hospitals and out of community pharmacies and put into PCNs. What's that done? It's doubled the price of locum pharmacists. So in the last two years we've seen a doubling of the price of locum pharmacists. We're actually now getting to a point where some PCNS are moaning they're losing pharmacists to go and locum in community and they can't afford to replace them. So what's happened is a Government policy has driven up the cost of pharmacists across all the healthcare settings."*[438]

Similarly the review into of integrated care systems led by Patricia Hewitt (the Hewitt review) identified the unintended consequence of the ARRS scheme:

> *"Contracts with national requirements can have unintended consequences when applied to particular circumstances. For instance, the national requirements and funding of Additional Roles Reimbursement Scheme (ARRS) roles for community pharmacists within PCNs, has on occasion exacerbated the problem of a general shortage of pharmacists, with some now preferring to work within primary care rather than remain in community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges."*[439]

Due to this impact on community pharmacy, as pharmacist independent prescribers and pharmacy technicians leave the sector for work in PCNs, some stakeholders concluded that this will ultimately negatively impact on patients and people in receipt of social care trying to access community pharmacy.[440] NHS Sussex Integrated Care concluded that:

> *"To fully realise the impact of the commitment for patients and service users, service planning will need to optimise the utilisation of pharmacist independent prescribers as part of pathway design/redesign."*[441]

The Department's submission sets out the various ways in which increased capacity and expertise will benefit patient access and safety, stating:

> *"By increasing independent prescribing capacity, we aim to improve patient pathways and increase patient choice. Additionally, clinical skills training for Pharmacy Technicians and Pharmacists will also support the delivery of patient care and improve the quality and safety of consultations with onward referrals where required. This work has also reduced pressure on other healthcare services as pharmacy teams are able to utilise their newly learnt skills and redirect appointments, freeing up capacity."*[442]

The Department's submission does however also recognise "challenges around backfill, and designated prescribing practitioner (DPP) training support", and commits to carrying out more work in 2023–24, including "extension and expansion of clinical examination

438 Stakeholder roundtable
439 The Hewitt Review, The Hewitt Review - An independent review of integrated care systems (April 2023)
440 NHS Nottingham and Nottinghamshire ICB (APE0013), British Oncology Pharmacy Association (APE0021)
441 NHS Sussex Integrated Care (APE0037)
442 Department of Health and Social Care (APE0039)

skills training" for community pharmacists, "education and clinical supervision access", as well as "capacity and capability for pharmacy workforce and trainees".[443]

Overall, the commitment has the potential to benefit patients and people in receipt of care, as staff become more skilled and there are a higher number of independent prescribers across the country, increasing access and availability for those needing prescriptions. Additional training is helpful, especially in the community pharmacy sector in increasing retention. However, ARRS funding leads to pharmacy professionals increasingly choosing better paid jobs in PCNs, and the benefit to PCNs comes at the expense of the community pharmacy sector. We therefore rated the impact aspect of this commitment as requires improvement.

Was it an appropriate commitment? Rating: Requires Improvement

Several submissions agree that the commitment is appropriate, and that the intended aims set out as part of it are needed for the sector.[444] Some submissions state that the barriers to success for this commitment have not been adequately considered, nor included in the commitment, which will lead to it not being met, and that this is therefore an argument against its being appropriate.[445] Some also conclude that this will lead to limited possible success.[446] NHS Nottingham and Nottinghamshire ICB stated:

> *"The commitment is completely appropriate and relevant, however incentives for uptake need to be more considered (e.g., backfill) to enable contracted pharmacy opening hours to be upheld. If the commissioning process for community pharmacy are not adequate to promote staff training in this way, then this essential upskilling will not be prioritised."*[447]

Concerns were also expressed regarding ensuring capacity to train, and there being enough services in place for the independent prescribers to work in once qualified.[448] Humber LPC stated:

> *"We have genuine concerns about how current trainee IPs are going to complete their training as it is, but, combined with the potential volume of newly qualified IP candidates also requiring placements and DPP's in a few very short years, we are worried about the scale of the preparatory work required being fully appreciated and supported. Locally we already have massive workforce shortages which may be further exacerbated if we have only a limited capability to train these new IPs meaning they will be trained elsewhere, and stay there, just making matters worse."*[449]

A participant at our roundtable similarly expressed concerns around the amount of time it would take to train those pharmacists wanting to become an independent prescriber, as well as ensuring there is enough work for them in community pharmacy:

443 Department of Health and Social Care (APE0039)
444 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016)
445 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Suffolk and North East Essex ICB (APE0010), NHS Sussex Integrated Care (APE0037)
446 NHS Dorset Integrated Care (APE0027)
447 NHS Nottingham and Nottinghamshire ICB (APE0013)
448 NHS Surrey Heartlands ICB (APE0006)
449 The Community Pharmacy Humber LPC (APE0032)

> *"The challenge we've got is that the programme the NHS currently has to get existing pharmacists trained up, it'll take to about 2040 before we have a meaningful number of pharmacists trained up. I'm not entirely sure if the health system can wait the 17 years it's going to take to build at the level it's at. The other thing we have, we'll get them all trained up, but there's nothing for them to do. We need commissioned services where they can actually prescribe against a budget for a meaningful need."*[450]

Although acknowledging the various challenges in meeting the commitment, such as access to DPPs and protected learning time, the Department's submission maintains that "education and training initiatives have supported the development and improvement of the clinical skills of a large part of the pharmacy workforce, shifting the balance of pharmacy activity and funding from dispensing activity towards clinical activity."[451]

However, based on the practical implications of the commitment not lining up with the aims set out in it, we conclude based on the evidence available to us that the appropriateness of this commitment 'requires improvement'.

Commitment 2: Better use of the skill mix

Overall Commitment Rating and Overview of better use of the skill mix: Inadequate

This commitment is based on a commitment made in the Year 3 of the CPCF (2021 to 2022):

> *"As soon as practicable, we will be seeking changes to medicines legislation to enable original pack dispensing and the wider use of hub and spoke dispensing to improve efficiencies and better use of the skill mix in pharmacy teams so that the clinical skills of pharmacists can be directed to helping patients. We will seek to enable these flexibilities within the CPCF as soon as possible."*[452]

Dispensing refers to the practical supplying of medicines by a pharmacy to the person receiving the medication.[453] Original pack dispensing (OPD) means that the medicine is dispensed to the person receiving the medication in its original packaging, and whole-pack dispensing that the amount of medication in the box provided is as it was assembled with the manufacturer rather than the pharmacist splitting a larger pack. Between 1 November and 13 December 2021, the Medicines and Healthcare products Regulatory Agency (MHRA) consulted on proposals to enable OPD and whole-pack dispensing of medicines containing sodium valproate in community pharmacies across the UK. The purpose of OPD and whole-pack dispensing for this medication in particular was due to its possible harmful effects if taken incorrectly. By ensuring the medication is dispensed in the original packaging, it will then be sure to include the manufacturer instruction and safety leaflet for the medication.[454] The Government's consultation concluded in March 2023, stating that due to the "the overall positive response, the government intends

450 Stakeholder roundtable
451 Department of Health and Social Care (APE0039)
452 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022) (August 2021)
453 NHSE, NHS Community Pharmacy Contractual Framework. Essential Service – Dispensing, accessed 120623
454 DHSC, Original pack dispensing and supply of medicines containing sodium valproate (November 2021)

to progress the proposals for OPD and the whole-pack supply of medicines containing sodium valproate." Therefore, the Government set out their commitment to amend part 12 of the Human Medicine Regulations 2012 in the consultation outcome document.[455]

Hub and spoke dispensing can be summarised as community pharmacies ("the spokes") outsourcing elements of the dispensing procedure to other pharmacies ("the hubs"). In Spring 2022 the Department consulted on legislative changes as part of the CPCF to allow to hub and spoke dispensing when the hub and spoke pharmacies are owned by different companies. They sought views on two potential models and on proposals to enable dispensing doctors (GPs who also dispense medicines and who generally serve remote or rural areas) to access hub pharmacies. The results of the consultation are forthcoming. In the consultation call, hub and spoke dispensing was described by the Government as:

> *"[…] when parts of the dispensing process are undertaken in separate pharmacy premises. Typically, there are many 'spoke' pharmacies to one 'hub' pharmacy. The concept is that the simple, routine aspects of assembling prescriptions can take place on a large scale in a 'hub' that usually makes use of automated processes. This means that pharmacists and other staff in the 'spokes' are freed up to provide more direct patient care."*[456]

The connection between OPD and whole-package and dispensing, and hub and spoke model and increased efficiency was summarised in the Government's consultation document for the hub and spoke model:

> *"These [hub and spoke model] proposed changes also align with policy proposals on original pack dispensing (OPD). Currently, pharmacists must supply the exact quantity of medicine prescribed. This means that where the quantity prescribed on a prescription is not equal to (or a multiple of) a pack size, pharmacy staff need to split a manufacturer's original pack in order to dispense the prescribed quantity, which takes time and reduces efficiency, particularly for the highly automated processes which hubs employ. The intention behind proposals for OPD is to allow pharmacies to make greater use of manufacturers' original packs, which in turn supports the greater use of automation. All of which supports the use of hub and spoke dispensing. OPD also has benefits even where automation and hub and spoke are not being utilised."*[457]

Overall, our rating of this commitment is that it is 'inadequate'. The commitment is vague in nature and does not set out when these legislative changes will be made nor the detail for what type of legislative changes it will seek to propose. It is therefore challenging to monitor progress and to hold the Government accountable on its progress.

Was the commitment met overall (or on track)? Rating: Inadequate

The submissions we have received, overall, agree that this commitment has not been met due to the legislation promised not yet being in place, although some submissions point to the disruption caused by the Covid-19 pandemic as a reason for this delay.[458] Many

455 DHSC, Original pack dispensing and medicines containing sodium valproate: consultation response (March 2023)
456 DHSC, Hub and spoke dispensing (March 2022)
457 DHSC, Hub and spoke dispensing (March 2022)
458 Pharmaceutical Services Negotiating Committee (APE0009), NHS Black Country ICB (APE0014), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (APE0038)

submissions point to the legislation introduced regarding VAT (Value Added Tax) as a positive first step in enabling better use of staff in community pharmacies, including pharmacy technicians,[459] but some stakeholders, including NHS Leicester, Leicestershire and Rutland ICB characterise the progress as "only minor".[460] One of the participants at our roundtable expressed concerns regarding barriers in utilising staff skills, and concluded:

> *"[…] we need an iterative and pragmatic framework of regulation and guidance that enables healthcare professionals, pharmacy professionals, to act in a way that enables safe supply of medicines and services. In such a way that you don't have somebody tied to a dispensing bench which doesn't help anybody."*[461]

The Department's submission sets out the Government's continued commitment to take forward legislative changes by the end of the 5- year CPCF (which concludes in 2025) and states that it is progressing to meet this commitment. The submission acknowledges that the process has been impacted by the Covid-19 pandemic which delayed the laying of the first phase of this legislative programme.[462] In their supplementary evidence, the Department stated:

> *"We are committed to pursuing legislative changes to level the playing field and enable all community pharmacies to make use of hub and spoke dispensing arrangements. We consulted on this last year and are currently finalising a response to the consultation. Our aim is to publish this as soon as possible. The timetable for bringing forward the implementing legislation will be dependent on the availability of parliamentary time across the 4 nations."*[463]

Overall we conclude that the Government's progress on this commitment is inadequate. From the Department's response to our evaluation, it is not clear about what the timeline for introducing the legislation is. Stakeholders agree that insufficient progress has been made on practically proposing the legislative changes promised in the commitment.

Was the commitment effectively funded (or resourced)? Rating: Inadequate

As most legislation is not yet in place, few submissions have addressed this point. However, some are concerned that the legislative changes will increase the workload in community pharmacies, but that this will not be accompanied by the funding to enable community pharmacies to carry out the additional tasks assigned to them as a result of these legislative changes.[464] NHS Nottingham and Nottinghamshire ICB argued that the changes set out in the commitment was essential in ensuring that community pharmacies could provide more clinical services, but added:

459 NHS Frimley Integrated Care (APE0020), Community Pharmacy Suffolk LPC (APE0029), The Community Pharmacy Humber LPC (APE0032), NHS Leicester, Leicestershire and Rutland ICB (APE0033), Community Pharmacy Suffolk LPC (APE0029), NHS Coventry and Warwickshire ICB (APE0025)

460 NHS Leicester, Leicestershire and Rutland ICB (APE0033)

461 Stakeholder roundtables

462 Department of Health and Social Care (APE0039)

463 Supplementary evidence provided by the Department of Health and Social Care (APE0041)

464 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033)

> *"Unfair to ask community pharmacies to provide more clinical services in the current financial climate whilst they are making a loss on dispensing."*[465]

The CCA states that there are areas where legislative changes have been made and where pharmacists have made relevant investment, but a delay in continued legislative change is stopping capitalisation of that initial investment.[466] Similarly the PSNC stated that:

> *"While the sector is very disappointed with the delays around the introduction of the promised efficiencies, there is recognition of the pressures DHSC has been under, particularly with the COVID-19 pandemic. It is though disappointing in the extreme that there has been no additional funding to support contractors delivering their side of the deal. As stated earlier, this issue was explored further in the 2021 annual review of the CPCF by DHSC, NHSE and PSNC."*[467]

A participant at the roundtable argued that it is difficult to ensure that there is a good skill mix when it is challenging to retain staff, due to pharmacy professionals leaving community pharmacy for better paid jobs in PCNs, which have benefited from ARRS scheme funding.[468]

The Department's submission does not explicitly set out what funding has been allocated to this commitment, but states that as part of policy development, the Department is working with regulators, professional leadership bodies and representatives of the sector to discuss and agree what support is required to effectively implement proposals "e.g. education and training needs, regulator/professional leadership body guidance etc.".[469]

Based on the evidence available to us, we conclude that the funding aspect for this commitment is inadequate. Firstly, the delay to, and lack of, legislative change in this area seems to suggest that the commitment is not being resourced, to prepare the workforce and realise the practical aims set out within it. There was widespread concern on the effect on community pharmacies in being delegated more tasks without the legislation to enable them to use staff more efficiently. Stakeholders also pointed to the difficult financial situation many community pharmacies are finding themselves in, and was critical regarding in this context about the expectation to deliver more clinical services whilst the legislative changes promised have not been delivered.

Did the commitment achieve positive impacts for patients and people in receipt of social care? Rating: Inadequate

Very few of the written evidence submissions we received addressed this point, which is understandable considering stakeholders agreed the commitment had not been met. PNSC concluded that the changes agreed as part of the 5-year CPCF has not been realised due to the delay in legislation, arguing that this has had a major impact on contractors and the success of the CPCF deal. PSNC argues that overall, the sector has delivered on its side of the 5-year deal, including providing the envisaged new services.[470] Community

465 NHS Nottingham and Nottinghamshire ICB (APE0013)
466 The Company Chemists' Association (APE0018)
467 Pharmaceutical Services Negotiating Committee (APE0009)
468 Stakeholder roundtables
469 Department of Health and Social Care (APE0039)
470 Pharmaceutical Services Negotiating Committee (APE0009)

Pharmacy Humber LPC however, raised their concerns regarding the timing of when legislative changes are to be introduced due to the cumulative effect of the impact of Covid-19 pandemic coupled with the challenges currently facing community pharmacy:

> *"Individually many of these are drastic changes but combined, and landing almost as one, if mishandled could be catastrophic to the sectors stability."*[471]

NHS Coventry and Warwickshire ICB similarly expresses concerns about the timing of the legislative changes:

> *"There is concern over the timing as this is likely to coincide with the start of the flu season and would be helpful if it could be achieved in advance of this i.e. July / August 2023."*[472]

NHS Frimley ICS was positive regarding the potential of the commitment to have a positive impact for patients and people in receipt of social care, stating that:

> *"The proposed legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists. This could lead to improved patient outcomes and a more efficient use of healthcare resources."*[473]

The Department's submission does not explicitly set out how the commitment will or is impacting on patients and people in receipt of social cares, but states that expanding the delivery of clinical patient facing services via community pharmacy, intends to relieve pressure on other parts of the health system.[474]

In conclusion, if met the commitment could deliver positive impacts on patients and people in receipt of social care as better use of pharmacy professionals could deliver better service. However, the delay in introducing the legislation whilst pharmacy providers have begun to introduce the services agreed in the CPCF risks having a negative impact on patients and people in receipt of social care. We conclude that due to the lack of progress on this commitment and the impact this delay, and the uncertainty of what is being introduced and when, has on the community pharmacy sector, the impact on patients and people in receipt of social care is 'inadequate'.

Was it an appropriate commitment? Rating: Inadequate

Many of the submissions we received argued that the commitment is not yet realised due to delay in legislative changes. Although the majority of submissions which address this commitment are positive regarding the aspiration of the commitment to improve skill-mix,[475] there were concerns about whether the commitment as worded could deliver this aspiration. NHS Greater Manchester Integrated Care acknowledged that roles within pharmacy also required "clear pathways and routes to entry", and added that increased

471 The Community Pharmacy Humber LPC (APE0032)
472 NHS Coventry and Warwickshire ICB (APE0025)
473 NHS Frimley Integrated Care (APE0020)
474 Department of Health and Social Care (APE0039)
475 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Greater Manchester Integrated Care (APE0016), NHS Frimley Integrated Care (APE0020), British Oncology Pharmacy Association (APE0021), Community Pharmacy Lincolnshire (APE0022), NHS Northamptonshire ICB (APE0023), National Pharmacy Association (APE0026), NHS Dorset Integrated Care (APE0027), NHS Leicester, Leicestershire and Rutland ICB (APE0033), Community Pharmacy Suffolk LPC (APE0029)

awareness and inclusion of the role of pharmacy technician to make it a more attractive role is needed to ensure there is a "secure pipeline" of pharmacy technicians entering the profession.[476] Community Pharmacy Lincolnshire added that a move to increase skill mix should also include support for community pharmacy providers to train more staff as pharmacy technicians, arguing that at present this is to a large extent funded by community pharmacy contractors and "carries a significant cost".[477] NHS Dorset Integrated Care similarly concludes that the commitment is only appropriate if the support and resources needed to realise the aspiration are readily available.[478]

The Department's submission does not indicate why the Government agrees this is an appropriate commitment. The submission does however mention aspects such as improved service delivery, relieving pressures on other parts of the health system and staff development.[479]

Although the intention of this commitment is appropriate, stakeholder submission seem to suggest that in isolation the commitment will not deliver the skill mix it envisions. The commitment is ambiguous in nature stating that the Government will "propose" legislation, and arguably vague its aspiration, which makes it challenging to scrutinise. Encouraging skill mix and better use of clinical skills in pharmacies is positive, however the way in which the Government will be preparing the workforce for this is unclear. Finally, we question whether changes to encourage skill mix can by themselves deliver what the Government set out in this commitment, or whether consequential legislation in medicines regulation would be needed in addition to this. We therefore conclude that the appropriateness of this commitment is 'inadequate'.

476 NHS Greater Manchester Integrated Care (APE0016)
477 Community Pharmacy Lincolnshire (APE0022)
478 NHS Dorset Integrated Care (APE0027)
479 Department of Health and Social Care (APE0039)

5 Extended services

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriateness	Overall
Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF.	Good	Requires improvement	Requires improvement	Good	Good

In this section we provide an assessment of Government commitments in relation to the extended services delivered by community pharmacy. One commitment was selected for evaluation:

"Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF."

Commitment: Test additional prevention and detection services

Overall Commitment Rating and Overview: Good

The PhIF was established in 2016 to "[…] support community pharmacy as it develops new clinical pharmacy services, working practices and digital platforms."[480]

It has supported the piloting of several advanced services by community pharmacy including referral pathways to the CPCS from GP practices and NHS 111 and expansion of the New Medicines Service (NMS).[481]

The commitment assessed in this chapter was introduced in year one of the CPCF 2019/20 – 2023/24.[482] The CPCF 2019/24 shifted the emphasis from dispensing towards the development of clinical services in community pharmacy and the integration of community pharmacy within primary care.[483] This reflects the aims of the 2019 NHS Long Term Plan which states:

480 NHS England, Pharmacy Integration Fund of £42 million announced, 20 October 2016
481 NHS, England, Pharmacy Integration Programme, accessed 220623
482 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)
483 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)

> *"We will boost "out-of-hospital" care, and finally dissolve the historic divide between primary and community health services."*[484]

The commitment assessed here specifically refers to prevention and detection services. As such, we have restricted our assessment to services within this area. When introducing this commitment in 2019, the CPCF stated that additional prevention and detection services could include:

> *"[…] a model for detecting undiagnosed cardiovascular disease (CVD) in community pharmacy and referral to treatment within PCNs, complementing the CVD service specification in the new GP PCN contract;*
>
> *the introduction of stop smoking support for those beginning a programme of smoking cessation in secondary care and referred for completion in community pharmacy;*
>
> *where supported by robust research, evaluation and training, using opportunities in the patient pathway to make further use of point of care testing around minor illness which could support efforts to tackle antimicrobial resistance;*
>
> *implementation of any recommendations from the ongoing review of vaccination and immunisation;*
>
> *the routine monitoring of patients, for example, those taking oral contraception, being supplied under an electronic repeat dispensing arrangement; and*
>
> *activity complementing the content of forthcoming PCN service specifications, for example, on early cancer diagnosis and in tackling health inequalities."*[485]

We have given an overall rating for this commitment of 'good'. The evidence we have reviewed confirms that pilots have taken place, and that three prevention and detection services have been rolled out through the CPCF. Stakeholders generally agree that community pharmacy is well placed to deliver these services and that they have the potential to positively impact on people using the services. The use of pilots to test services prior to national rollout was thought to be appropriate but concerns were raised about the lack of publicly available outcome data from pilots. There were also widely held concerns regarding the adequacy of the funding for these services once they are mainstreamed within the CPCF.

Was the commitment met overall (or on track)?

Rating: Good

Since 2019, three prevention and detection services have been piloted and subsequently rolled out through the CPCF:

- The hypertension case-finding service was piloted in 2020/21 and mainstreamed in year 3 of the CPCF.[486]

484 NHS England, The NHS Long Term Plan (January 2019)
485 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)
486 NHS England, NHS community pharmacy blood pressure check service (November 2021); DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022) (August 2021)

- The smoking cessation service for people discharged from hospital was also piloted in 2020/21 mainstreamed in year 3 of the CPCF.[487]
- Tier 1 of the oral contraception service (ongoing monitoring and supply of repeat oral contraception prescriptions to prevent unwanted pregnancy) was introduced in year 5 of the CPCF.[488]

The Department's submission stated:

> *"A number of clinical services have been piloted and evaluated through the Pharmacy Integration Fund (PHIF), and the commitment to testing new clinical services through the Pharmacy Integration Fund has played a significant role in improving the healthcare system in a number of key areas."*[489]

Most NHS organisations that submitted written evidence confirmed that community pharmacies in their area had engaged with pilots and/or one of the three prevention and detection services that were mainstreamed within the CPCF.[490] The PSNC reported:

> *"Pharmacy contractors have engaged well with the first two services, with over 9,000 registered to provide the Hypertension Case-finding Service and over 4,000 registered to provide the Smoking Cessation Service."*[491]

However, despite confirming that they had engaged with pilots, some NHS organisations stated that they were unable to comment on whether the commitment had been met because it does not specify a target number of services to be piloted or mainstreamed.[492] For example, NHS Nottingham and Nottinghamshire ICB confirmed that pharmacies in their ICB had engaged with pilots but wrote:

> *"This commitment is a broad statement without definitions or numbers of services, so it is hard to comment beyond this."*[493]

Similarly, NHS Black Country ICB, who had also participated in pilots of services, wrote:

> *"Without knowing DHSC's full intentions for additional services, we cannot comment on whether the commitment was met."*[494]

Many written submissions also pointed to the lack of publicly available outcome data from NHS England as a reason that it was difficult to assess whether the commitment had been met.[495]

487 NHS England, NHS community pharmacy smoking cessation service, accessed 220623; DHSC, Community Pharmacy Contractual Framework 5-year deal: year 3 (2021 to 2022) (August 2021)
488 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 5 (2023 to 2024) update for contractors (September 2022)
489 Department of Health and Social Care (APE0039)
490 NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), Avon LPC (APE0017), NHS Frimley Integrated Care (APE0020), NHS Coventry and Warwickshire ICB (APE0025)), NHS Dorset Integrated Care (APE0027), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), Humber LPC (APE0032), Leicester, Leicester and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034)
491 Pharmaceutical Services Negotiating Committee (APE0009)
492 NHS Surrey Heartlands ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034)
493 NHS Nottingham and Nottinghamshire ICB (APE0013)
494 NHS Black Country ICB (APE0014)
495 Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk and North East ICB (APE0010)), NHS Nottingham and Nottinghamshire ICB (APE0013), Avon LPC (APE0017), NHS Dorset Integrated Care (APE0027), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), Humber LPC (APE0032), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), Royal Pharmaceutical Society (RPS) (APE0038).

In summary, three prevention and detection services have been piloted through the PhIF and subsequently rolled out through the CPCF and most NHS organisations that submitted evidence confirmed that they have engaged with pilots and/or one of the mainstreamed services. Therefore, in the absence of a specified target in the commitment, we have rated this area as 'good'.

Was the commitment effectively funded (or resourced)?

Rating: Requires improvement

Pilots are funded through the PhIF and once services are mainstreamed, they are funded through the CPCF. Community pharmacy receives an annual global sum through the CPCF to cover both dispensing and clinical services.[496] The Department confirmed in their submission that no additional investment is added to the global sum to support new prevention and detection services when they are commissioned through the CPCF.[497]

Most evidence submissions spoke to the funding of mainstreamed services through the CPCF rather than the funding of pilots. Two ICBs that specifically commented on the funding of pilots reported that it was adequate.[498] However, NHS Leicester and Leicester Rutland ICB wrote:

> *"There are resource limitations for these pilots regarding project management, support on the ground and IT systems."*[499]

Most stakeholders stated that the funding of services once they were mainstreamed within the CPCF was not sufficient.[500] NHS West Yorkshire ICB wrote:

> *"Pilots are funded to deliver on implementation and resourced accordingly. The more wholescale approach to implementation as these services are included in the CPCF do not come with that same level of resource including aspects like IT which do sometimes present barriers for implementation."*[501]

We heard from many stakeholders that funding additional services through the global sum within the CPCF means that less money is available for dispensing.[502] For example, NHS Surrey Heartlands ICB stated:

> *"The consequences are a dilution of the global sum resulting in reduced payments for dispensing fees due to payments for an increased volume in service activity."*[503]

496 DHSC, Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (July 2019)
497 Department of Health and Social Care (APE0039)
498 NHS Coventry and Warwickshire ICB (APE0025), NHS West Yorkshire ICB (APE0034)
499 NHS Leicester, Leicestershire and Rutland ICB (APE0033)
500 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and NHS North East Essex ICB (APE0010)), Pharmacy2U (APE0015), The Company Chemists' Association (CCA) (APE0018), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), Humber LPC (APE0032), NHS Sussex Integrated Care (APE0037)
501 NHS West Yorkshire ICB (APE0034)
502 NHS Surrey Heartlands ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010)), Pharmacy2U (APE0015), The Company Chemists' Association (CCA) (APE0018), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), Humber LPC (APE0032), NHS Sussex Integrated Care (APE0037)
503 NHS Surrey Heartland ICB (APE0006)

This opinion was also expressed by participants in the roundtable discussions. One of whom said:

> *"There seems to be a kind of bonkers thinking at the moment where the NHS keeps on commissioning and keeps on asking pharmacy to do more, but they can't afford anymore."*[504]

Later in the discussion, the same participant added:

> *"So, the number of services is drying up because the way in which the framework is designed is that it's a fixed sum. So, as they do more and more blood pressure checks, they get paid less and less for dispensing. So, any money they earn in addition for doing more services comes off what they can earn in the dispensing side of things."*[505]

NHS Suffolk and North East Essex ICB noted that not all pharmacies in their area had chosen to deliver extended services and attributed the patchy uptake to the "potentially 'punitive' national funding mechanism" and workforce pressures.[506]

The 2023 Pharmacy Pressures Survey conducted by PSNC which surveyed over 900 pharmacy owners (representing 6,200 pharmacy premises) and over 2,000 pharmacy team members from 31 January – 26 February 2023 reported:

> *"[…] the majority (96%) of pharmacy owners are facing significantly higher costs than last year—up from 80% in the 2022 pressures survey—and many are operating understaffed due to both insufficient funding (48%) and staff unavailability (34%)."*[507]

In March 2023, PSNC warned Ministers that no more services should be rolled out without additional funding. In a news item on the PSNC website, Janet Morrison, chief executive of PSNC stated:

> *"Our position is very clear: pharmacy businesses are on the brink of collapse so it makes no sense whatsoever to add any further services or requirements for 2023/24 without additional funding."*[508]

NHSE, however, launched tier 1 of the Pharmacy Contraception Service in April 2023.[509] The RPS reported in their submission that many contractors had chosen not to engage with the contraception services due to inadequate funding within the CPCF[510] and the CCA wrote:

> *"It is a matter or deep concern that the service has been rolled out despite the warnings of the negotiator that no new or expanded services should be rolled out in 2023/2024 without additional funding. As a result, many contractors are choosing not to deliver the service."*[511]

504 Stakeholder roundtable
505 Stakeholder roundtables
506 NHS Suffolk and North East Essex ICB (APE0010)
507 Pharmaceutical Services Negotiating Committee, "Pressures Survey confirms rising costs, patient demand and medicine supply issues continue to grip community pharmacy", 13 April 2023
508 Pharmaceutical Services Negotiating Committee, "Year 5 CPCF services cannot go ahead without funding uplift", 13 March 2023
509 DHSC, Community Pharmacy Contractual Framework 5-year deal: year 5 (2023 to 2024) update for contractors (May 2023)
510 Royal Pharmaceutical Society (RPS) (APE0038)
511 The Company Chemists' Association (CCA) (APE0018)

In addition to concerns about the funding of the additional services, we were told by Community Pharmacy Suffolk (Suffolk LPC) that:

> *"When the [piloted] service is then commissioned as a national service, quite frequently the enablers that created successful outcomes in the pilot are not put in place to support implementation of the full service."*[512]

Inadequate IT connectivity between community pharmacy and the wider NHS was the most frequently highlighted problem by stakeholders.[513] For example, NHS Dorset Integrated Care wrote:

> *"Digital and IT are huge barriers to delivery of services, these are costly and are not included in funding models."*[514]

A stakeholder at one of the roundtables further elaborated on the negative impact of inadequate IT systems on the delivery of the hypertension case-finding service:

> *"It's taking pharmacists longer to enter the data into the five different systems that they need to use rather than actually doing the case finding itself."*[515]

Workforce pressures were also highlighted as a barrier to the delivery of prevention and detection services.[516] A participant in the roundtables called for increased financial support for the community pharmacy workforce, in line with the ARRS in primary care.[517] The ARRS scheme aims to increase capacity in PCNs by reimbursing the salaries of new staff in certain roles, including pharmacists and pharmacy technicians.[518] Three submissions also highlighted the importance of the Community Pharmacy Clinical lead role to support on the ground project management of services and expressed concern that this role is currently only funded until March 2024.[519]

In the recently published Delivery plan for recovering access to primary care, Government states that it will:

> *"Invest up to £645 million over the next two years to expand community pharmacy services, subject to consultation."*[520]

Some stakeholders referred to this investment in their submissions.[521] However, whilst the delivery plan does commit to expanding the existing hypertension case-finding and

512 Community Pharmacy Suffolk (Suffolk LPC) (APE0029)
513 NHS Surrey Heartland ICB (APE0006), Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk and North East Essex ICB (APE0010)), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Northamptonshire ICB (APE0023), NHS Dorset Integrated Care (APE0027), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), Humber LPC (APE0032), NHS Leicester, Leicester and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), Royal Pharmaceutical Society (RPS) (APE0038)
514 NHS Dorset Integrated Care (APE0027)
515 Stakeholder roundtables
516 NHS Suffolk and North East Essex ICB (APE0010), NHS Northamptonshire ICB), (APE0023), NHS Coventry and Warwickshire ICB (APE0025), Community Pharmacy Humber LPC (APE0032).
517 Stakeholder roundtables
518 NHSE, Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance (December 2019)
519 NHS Black Country ICB (APE0014), NHS Northamptonshire ICB (APE0023), NHS Leicester, Leicestershire and Rutland ICB (APE0033).
520 NHSE, Delivery plan for recovering access to primary care (May 2023)
521 Pharmaceutical Services Negotiating Committee (APE0009), Royal Pharmaceutical Society (RPS) (APE0038), Pharmacy2U (APE0015)

contraception services, the key new service launched in the plan, Pharmacy First, is a diagnostic and treatment service and therefore falls outside the remit of the commitment assessed here. For this reason, and because the investment remains subject to consultation, we have not considered this new investment in our assessment of the funding for this commitment.

In summary, whilst funding and infrastructure for pilots was deemed adequate by some ICBs, this is not replicated when services are mainstreamed within the CPCF. As a result, community pharmacy is being asked to deliver additional services without additional investment and at a time when they are already experiencing increased costs and pressures. Therefore, we rate the funding for this commitment 'requires improvement'.

Did the commitment achieve positive impacts for patients and people in receipt of social care?

Rating: Requires improvement

In their submission, the Department stated:

> *"The evaluation of the pilots includes review and analysis of a combination of quantitative and qualitative data sources, with consideration as to operational feasibility; patient, GP, community pharmacy, other stakeholder acceptability; digital readiness and governance. Evaluations include the views of both pharmacists and patients, general practice and secondary care staff."*[522]

In their additional evidence submission, the Department gave further information on the method of pilot evaluation:

> *"For each service that has been piloted or tested via the Pharmacy Integration programme, an evaluation plan is developed and a Logic model is developed where outputs and outcomes are identified working across with NHSE Pharmacy data analyst team. The evaluation strategy is taken through internal governance process to review and approve.*
>
> *Since Autumn 2022 an Expert evaluators reference group has been informing the evaluation strategies we develop. The group was recruited through an open EOI [expression of interest] process. Members are drawn from academia, evaluation organisations and NHS analysts."*[523]

Case studies describing positive results from one hypertension case-finding pilot and one smoking cessation pilot are available on the NHS website.[524] However, many stakeholders reported that the full evaluations of all pilots are not publicly available.[525] NHS Suffolk and North East Essex ICB wrote:

522 Department of Health and Social Care (APE0039)

523 Supplementary evidence provided by the Department of Health and Social Care (APE0041)

524 NHS England, Case study: NHS community pharmacy blood pressure check service, accessed 220623, NHS England, Case study: smoking cessation transfer of care from hospital to community pharmacy pilot, accessed 220623

525 Pharmaceutical Services Negotiating Committee (APE0009), NHS Suffolk & North East Essex ICB (APE0010)), NHS Nottingham and Nottinghamshire ICB (APE0013), Avon LPC (APE0017), NHS Dorset Integrated Care (APE0027), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), Humber LPC (APE0032), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), Royal Pharmaceutical Society (RPS) (APE0038).

> *"The visibility of pilot evaluations prior to national rollout is perceived as poor—recent examples include the contraception service and UEC NHS CPCS."*[526]

And NHS Dorset Integrated Care wrote in their submission that:

> *"[…] lots of services have been rolled out when pilots have not been fully completed and evaluated."*[527]

Of the submissions that did report outcome data, the CCA stated that there were:

> *"600,000 blood pressure checks last year. 44% of these took place in the 30% most deprived parts of England—indicating the potential this service has to reduce health inequalities."*[528]

Despite noting the absence of formal outcome data, many stakeholders provided anecdotal examples of the positive impact of extended detection and prevention services, particularly in terms of improving access to services.[529] For example, NHS Nottingham and Nottinghamshire ICB wrote:

> *"The pilots are evaluated by NHSE and information such as this is held by NHSE. Some soft intelligence regarding the contraception pilot in the Nottingham and Nottinghamshire area has shown a positive impact for a patient who had been trying to get an appointment for a repeat supply of oral contraceptive and a pill check with their GP but had found this challenging. They accessed the service at the community pharmacy instead had their consultation and left with their repeat supply of oral contraception all in one visit and were pleased to be able to access the service from their local community pharmacy."*[530]

And NHS Sussex Integrated Care reported:

> *"The service provision benefits patients to enable a greater number of access points for these services and with increased opening hours for evening and weekend provision."*[531]

A participant at the roundtables with lived experience as of receiving social care and as a carer for a family member was enthusiastic about the delivery of extended detection and prevention services in community pharmacy:

> *"I'm very impressed on a positive note how the roles of the pharmacists are becoming more and more broader, in terms of they're no longer just giving you medicine over the counter, they do loads of different things like health checks, blood pressure checks, diabetes checks. […] So pharmacy is no longer what we used to think of it, a corner shop with a chemist sign outside."*[532]

526 NHS Suffolk and North East Essex ICB (APE0010))
527 NHS Dorset Integrated Care (APE0027)
528 The Company Chemists' Association (CCA) (APE0018)
529 NHS Surrey Heartland ICB (APE0006), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034), NHS Sussex Integrated Care (APE0037), Humber LPC (APE0032)
530 NHS Nottingham and Nottinghamshire ICB (APE0013)
531 NHS Sussex Integrated Care (APE0037)
532 Stakeholder roundtables

In summary, many of the ICBs agreed that prevention and detection services have the potential to positively impact on people using the services. However, evidence submissions noted the lack of publicly available evaluations of pilots, and lack of formal outcome data regarding the impact on people using the services. Therefore, in the absence of readily available outcome data, we conclude that the positive impact of this commitment has not been objectively demonstrated. As such, we have rated this area as 'requires improvement'.

Was it an appropriate commitment?

Rating: good

Many stakeholders agreed that it is appropriate for community pharmacy to deliver detection and prevention services[533]. The main reason given for this was that community pharmacy is more accessible to the public than other healthcare settings. For example, NHS Suffolk and North East Essex ICB wrote:

> *"[…] the COVID-19 pandemic highlighted the value of the community pharmacy network in its accessibility for patients and the significant impact the sector has (and could develop further) in improving public health and prevention. Therefore, the development of the above prevention and detection services is welcomed."*[534]

NHS Nottingham and Nottinghamshire ICB wrote:

> *"The services are seen to support the important role community pharmacy teams can play to help address health inequalities by providing wider healthcare access in their communities and in the case of the contraception service signposting service users to local sexual health services in line with NICE guideline NG102*[535]*."*[536]

National Voices, a coalition of over 200 health and social care charities in England, also agreed that the increased accessibility of community pharmacists makes them well placed to deliver detection services:

> *"Pharmacists are often more accessible than other primary healthcare professionals, such as GPs, as people can walk into their local pharmacy and access help and support at a time and in a way which is right for them. Being in more convenient locations, with less travel time involved, being open for longer hours, providing faster access, and being more accommodating to community languages—all of these factors mean that community pharmacies can help patients get earlier diagnosis and better manage their health conditions."*[537]

533 NHS Suffolk and North East Essex ICB (APE0010), NHS Nottingham and Nottinghamshire ICB (APE0013), Pharmacy2U (APE0015), National Pharmacy Association (APE0026), NHS Dorset Integrated Care (APE0027), The Pharmacists' Defence Association (PDA) (APE0030), NPA's Women Members Forum (APE0031), Leicester, Leicester and Rutland ICB (APE0033), Royal Pharmaceutical Society (RPS) (APE0029)

534 NHS Suffolk and North East Essex ICB (APE0010))

535 The National Institute for Health and Care Excellence is an executive non-departmental public body sponsored by the Department of Health and Social Care. NICE provides national guidance and advice to improve health and social care. NICE guideline NG102 covers how community pharmacies can help maintain and improve people's health and wellbeing. NICE, Community pharmacies: promoting health and wellbeing (August 2018)

536 NHS Nottingham and Nottinghamshire ICB (APE0013)

537 National Voices (APE0035)

Many stakeholders also agreed that it was sensible to conduct pilots of new services prior to national rollout.[538] NHS Black Country ICB wrote in their submission that:

> *"[piloting] a range of services can enable challenges and issues (e.g., IT) to be dealt with at an early stage, so that when services are ultimately released, they can be delivered safely and effectively."*[539]

However, some stakeholders caveated their positive opinion on the appropriateness of the commitment by stating the requirement that new services are supported with adequate funding, appropriate IT infrastructure and sufficient workforce.[540] For example, NHS Dorset Integrated Care wrote:

> *"This was an appropriate commitment, but only with the appropriate support and resources readily available."*[541]

And NHS Surrey Heartlands ICB agreed that it was an appropriate commitment but:

> *"[…] needed specific timescales and implementation support for IT at a national level."*[542]

Some stakeholders also noted that the commitment did not contain a specific target number of services to be piloted or delivered.[543] For example, NHS Surrey Heartlands ICB described the commitment as:

> *"No ambition expressed, very top line commitment with no specific detail […] No specific target identified."*[544]

And others thought that the commitment was not ambitious enough. For example, some suggested that the hypertension case-finding service could be expanded to capture more cardiovascular risk factors including lipid monitoring, glucose testing or atrial fibrillation detection.[545] A participant in the roundtable discussions said that the current services focussed primarily on primary prevention and that:

> *"[…] we've completely missed a lot of the opportunities around secondary prevention and the role that pharmacy could play in that"*[546]

In summary, we heard that community pharmacy is appropriately placed to deliver prevention and detection services. Stakeholders agree with the concept of piloting new services prior to national rollout and agree that these services have the potential to positively impact the health of those using the service. However, many stakeholders emphasised that

538 NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Greater Manchester Integrated Care (APE0016), NHS Northamptonshire ICB (APE0023), Community Pharmacy Suffolk (Suffolk LPC) (APE0029), NHS West Yorkshire ICB (APE0034)

539 NHS Black Country ICB (APE0014)

540 NHS Surrey Heartland ICB (APE0006), NHS Suffolk and North East Essex ICB (APE0010)), NHS Dorset Integrated Care (APE0027), Royal Pharmaceutical Society (RPS) (APE0038)

541 NHS Dorset Integrated Care (APE0027)

542 NHS Surrey Heartland ICB (APE0006)

543 NHS Surrey Heartlands ICB (APE0006), The Stroke Association (APE0008), NHS Nottingham and Nottinghamshire ICB (APE0013), NHS Black Country ICB (APE0014), NHS Leicester, Leicestershire and Rutland ICB (APE0033), NHS West Yorkshire ICB (APE0034)

544 NHS Surrey Heartlands ICB (APE0006)

545 The Stroke Association (APE0008), Royal Pharmaceutical Society (RPS) (APE0038), National Pharmacy Association (APE0026)

546 Stakeholder roundtables

community pharmacy must be appropriately resourced in terms of funding, workforce and IT infrastructure to deliver the services and some felt that the commitment could be more specific and ambitious to realise the maximum potential of these services. Based on this evidence we rated the appropriateness of this commitment as 'good'.

Annex A: Anchor statements for CQC-style ratings

Rating	Was the commitment met overall/Is the commitment on track to be met?	Was the commitment effectively funded?	Did the commitment achieve a positive impact for patients?	Was it an appropriate commitment?
Outstanding	The commitment was fully met/there is a high degree of confidence that the commitment will be met	The commitment was fully funded with no shortfall	Patients and stakeholders agree that the impact was positive	Evidence confirms appropriateness of the commitment
Good	The commitment was met but there were some minor gaps, or is likely to be met within a short time after the deadline date/it is likely that the commitment will be met, but some outstanding issues will need to be addressed to ensure that is the case	The commitment was effectively funded, with minor shortfalls	The majority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment was appropriate overall, with some caveats
Requires improvement	The commitment has not been met and substantive additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if substantive additional steps are taken	The commitment was ineffectively funded	A minority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment needs to be modified
Inadequate	The commitment has not been met and very significant additional steps will need to be taken to ensure that it is met within a reasonable time/ the commitment will only be met if very significant additional steps are taken	Significant funding shortfalls prevented the commitment being met	Most patients and stakeholders did not agree there was a positive impact for patients	Evidence suggests the commitment was not appropriate

Annex B: Published written submissions

The following written submissions were received and can be viewed on the inquiry publications page of the Committee's website.

(1) Dr Ali Hindi, University of Manchester (APE0001)

(2) NHS Gloucestershire ICB (APE0002)

(3) Professor Ian Maidment, Aston University (APE0004)

(4) NHS Surrey Heartlands ICB (APE0006)

(5) Anonymised (APE0007)

(6) The Stroke Association (APE0008)

(7) Pharmaceutical Services Negotiating Committee (APE0009)

(8) NHS Suffolk and North East Essex ICB (APE0010)

(9) HubRx Ltd (APE0011)

(10) NHS Nottingham and Nottinghamshire ICB (APE0013)

(11) NHS Black Country ICB (APE0014)

(12) Pharmacy2U (APE0015)

(13) NHS Greater Manchester Integrated Care (APE0016)

(14) Avon LPC (APE0017)

(15) The Company Chemists' Association (APE0018)

(16) Care England (APE0019)

(17) NHS Frimley Integrated Care (APE0020)

(18) British Oncology Pharmacy Association (APE0021)

(19) Community Pharmacy Lincolnshire (APE0022)

(20) NHS Northamptonshire ICB (APE0023)

(21) NHS North East London ICB (APE0024)

(22) NHS Coventry and Warwickshire ICB (APE0025)

(23) National Pharmacy Association (APE0026)

(24) NHS Dorset Integrated Care (APE0027)

(25) Omnicell (APE0028)

(26) Community Pharmacy Suffolk LPC (APE0029)

(27) The Pharmacists' Defence Association (APE0030)

(28) The NPA Women Members' Forum (APE0031)

(29) The Community Pharmacy Humber LPC (APE0032)

(30) NHS Leicester, Leicestershire and Rutland ICB (APE0033)

(31) NHS West Yorkshire ICB (APE0034)

(32) National Voices (APE0035)

(33) NHS Sussex Integrated Care (APE0037)

(34) Royal Pharmaceutical Society (RPS) (APE0038)

(35) Department of Health and Social Care (APE0039)

(36) NHS Bedfordshire, Luton and Milton Keynes ICB (APE0040)

(37) Supplementary evidence provided by the Department of Health and Social Care (APE0041)

Annex C: Transcripts

Roundtables with people who have lived experience of pharmacy services in England and their representatives:

- Group 3 Event 1 (APE0044)
- Group 5 Event 2 (APE0048)

Roundtables with pharmacy professionals:

- Group 1 Event 1 (APE0042)
- Group 2 Event 1 (APE0043)
- Group 1 Event 2 (APE0045)
- Group 2 Event 2 (APE0049)
- Group 3 Event 2 (APE0046)
- Group 4 Event 2 (APE0047)