ROYAL PHARMACEUTICAL SOCIETY

Pharmacy Inquiry

Royal Pharmaceutical Society Submission

The Royal Pharmaceutical Society is the professional body for pharmacists and pharmacy in Great Britain, representing pharmacists working in all sectors. Pharmacy is the third largest health profession after medicine and nursing, with more than 62,000 pharmacists and 24,000 pharmacy technicians on the General Pharmaceutical Council register.[1]

Pharmacists work in many different settings, developing new medicines, supplying medicines, providing advice about medicines, and offering health services. 25% of pharmacists are prescribers.

Pharmacists have the widest knowledge in the science and use of medicines, the most common form of treatment in the NHS. The total expenditure on medicines in England by the NHS in 21/22 was estimated to be £17.2 billion[2]. For patients medicines can be life-prolonging and life-saving. However, they can also cause harm and lead to unnecessary wastage if used incorrectly.

Pharmacists are experts in medicines and their use and should be available at all points in the patient pathway where medicines are procured, prescribed, optimised, dispensed and supplied, as well as being there to support the person taking the medicine. Involving pharmacists and pharmacy teams more in the optimisation of medicines for individuals will lead to better outcomes for patients and better value for the wider system. Consistent use of pharmacists' expertise will also help reduce adverse reactions to medicines, minimise avoidable harm and un-planned admissions to hospital.

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

1. RPS worked in collaboration with the Kings Fund to develop a vision for pharmacy in England which outlines key ambitions for the future of pharmacy and how it can support patient care in England over the next decade.[3] This vision outlines three key areas where pharmacy can be developed to support the care of patients and the public. The vision also outlines the enablers that would make this happen and these are the areas where the government can help to ensure that the vision is realised.

2. Over the last two decades, the expertise of pharmacists has increasingly been used to deliver better use of medicines, improved knowledge around safe use of medicines, technical delivery and governance of novel personalised therapies, support for public health and more clinically focused care to patients and the public. In parallel, pharmacy technician roles have become registered, and expanded to include a breadth of technical and clinical practice.

3. More pharmacy professionals are being integrated into multidisciplinary teams and local systems across primary care, in general practice and in community and hospital pharmacy. The shift towards pharmacy teams delivering personalised care is becoming more visible to the healthcare system. As the value of this shift is realised it has the potential to create the pace and momentum for change.

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[1] https://www.pharmacyregulation.org/about-us/research/gphc-registers-data (February 2023)
[2] https://www.nhsbsa.nhs.uk/statistical-collections/prescribing-costs-hospitals-and-community-england/prescribing-costs-hospitals-and-community-england-202122#:~:text=The%20total%20cost%20to%20NHS%20commissioners%20(known%20as%20actual%20cost,619%20million%20for%20central%20rebates.
[3] https://www.rpharms.com/england/vision-for-pharmacy-practice-in-england

4. Integrated Care Systems (ICSs) can enable the integration of pharmacy teams with the wider health and care system in a way and at a scale previously not achieved, resulting in improved access to care for patients.

5. Changes in pharmacist education, enabling pharmacists to prescribe on registration with enhanced clinical, population health and consultation skills, alongside the use of skill mix in pharmacy teams, will unlock the potential to increasingly take on leadership, public health, diagnostic and treatment roles across health and social care.

6. If supported to succeed, pharmacy teams over the next ten years can transform the way that they provide care to every community in England.

    - We would like to see integration of pharmacy teams across health and care systems that enable them to support people to improve their health and stay well. For example, we want pharmacy teams to help transform the lives of people living in deprived communities, those experiencing health inequalities, or anyone excluded from care.
    - We want pharmacists to provide person-centred care and shared-decision making that enables all people to live well with the medicines they take. For example, we want to see prescribing pharmacists and pharmacy technicians embedded as part of digitally connected multidisciplinary teams supporting anyone living with complex medicines needs and long-term conditions.
    - Pharmacy teams will enhance patient experience and access to care. For example, we want to see people get care from pharmacy teams in a way that suits them using innovations in patient-facing digital technology, remote monitoring and Artificial Intelligence.

7. In order for this to happen there are a number of enablers that need to be put in place:

    - We want pharmacy professionals to be able to work at the top of their abilities to deliver increasingly integrated care to patients and the public, and to provide expertise to the wider healthcare system. For example, by routinely collecting workforce data nationally and locally, to inform a one system approach to workforce planning for all pharmacy staff groups. This goes beyond registered pharmacists, but includes the whole pharmacy team, including pharmacy technicians, pharmaceutical scientists and the wider pharmacy workforce.

      Government can support the implementation of the national workforce plan that not only considers the numbers but also the education and training of pharmacy staff. This plan must be reviewed and updated regularly.

    - Data, innovation, science and research needs to be used by pharmacy teams to personalise care and medicines use. For example, by developing skills to capitalise on the data and digital revolution to provide targeted interventions and service improvements that improve individual and population health. Ensuring technical services are developed to deliver aseptic medicines and personalised medicines such as Advanced Therapy Medicinal Products (ATMPs) and radiopharmaceuticals and ensuring clinical trials can be delivered by pharmacy professionals is critical for research and development in the UK. Agility by the Medicines and Healthcare products Regulatory Authority (MHRA) in Marketing Authorisation (MA) review, approval of variations to MAs, review and approval of Clinical Trial Authorisations (CTAs), approval of amendments to CTAs, review and approval of Manufacturing and Import Authorisations (MIA), Manufacturing and Import Authorisations for Investigational Medicinal Products (MIA(IMP)) and Manufacturers Specials (MS) authorisations is needed. Agility by the Government in amending medicines regulations to ensure that ambiguity in existing law is removed. This is essential to ensure the continued supply of medicines, for new medicines, for innovation

and to make the UK attractive as a pharmaceutical manufacturing location to align with the Life Sciences Vision[4]. Delivering genomic testing and personalised medicines will improve outcomes for people. Having access to shared information across the system is key to this.

Government can ensure pharmacists working in all care settings have access to relevant patient information to support them in the delivery of care for the individual patient. They can remove the barriers to ensure pharmacists are supported and trained in digital advancements that support patient care.

- Pharmacy professional practice across the healthcare system will be transformed by leadership, collaboration and integration. For example, through collaborative and diverse leadership, with pharmacy organisations working together, pharmacy leaders as part of multidisciplinary leadership teams working across systems, and pharmacy professionals developed and supported to become local leaders. Much of pharmacists' work will be enabled by community pharmacy working in partnership with place-based multidisciplinary teams across primary care.

  Government can ensure that pharmacists are included as leaders in ICS to enable them to deliver pharmaceutical care across systems. We strongly believe that every ICS should have a Chief Pharmacist, operating at executive level, to support the use of medicines and pharmacy across each system.

8. We need to ensure that pharmacy technicians have the skills and ability to provide much of the dispensing role, as well as evolving their clinical roles, and therefore free up pharmacist capacity to focus more on the complex and high-risk medications.

9. Pharmacists and pharmacy teams are playing a central role in the wider use of pharmacogenetics and greater personalisation of medications, particularly around management of long-term conditions. This trend needs to continue and develop.

10. There also needs to be further investment in hospital pharmacy homecare services as funding is currently haphazard. Homecare patient schemes and patient numbers are rising exponentially with little additional investment. It is a vitally important service for many chronically ill patients. Homecare services are key, both for patient experience and for supporting the elective recovery plan as it frees up clinic space, especially for infusions.

11. Incentivising community pharmacists to work with patients and the public to support adherence to medication regimes and reduce waste needs to be implemented and where appropriate, providing in-reach services to settings such as care homes to support providers in optimising medicines management.

12. As experts in medicines, pharmacists have a professional responsibility to take a leading role in reducing the environmental impact of medicines use. Medicines have three major impacts on the environment: the chemical effects of the Active Pharmaceutical Ingredients (APIs) themselves, the large carbon footprint involved in manufacture and distribution, and pharmaceutical waste. There is much that pharmacists and their teams can do to take action on climate change[5].

[4] https://www.gov.uk/government/publications/life-sciences-vision

[5] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/pharmacys-role-in-climate-action-and-sustainable-healthcare

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

13. Like many professions, the pharmacy workforce is facing many challenges, including workforce numbers not matching the demand. Whilst we welcome the expansion of pharmacy training places and the increased clinical role for pharmacists outlined in the recently published NHS Long Term Workforce Plan (NHS LTWP)[6], the plan does not provide adequate assurance of long-term funding for pharmacy. Any workforce plan should consider the essential core roles and responsibility that must be delivered across all sectors of pharmacy. The plan must seek to provide a consistent level of service for the public. and enable pharmacists to maintain up to date knowledge on existing medicines in addition to developing knowledge on new medicines to ensure patient safety via protected learning time. This must be backed by appropriate investment in education and training.

14. Workforce planning must include collating transparent data around current roles and services which make up current workforce activity across all sectors of the pharmacy professions and across the breadth of medicines for human use. Data should include workforce establishment, technical skills required for medicines delivery and handling, vacancy rates and turnover, broken down by grades, roles, sector and geography. These data are required to provide the bigger picture alongside further information such as reasons for leaving roles, age profiles and Equality, Diversity and Inclusion metrics. These data, alongside specific country ambitions, should be used to inform future workforce models and what workforce will be required to deliver it.

15. Current recruitment approaches which significantly increase the number of pharmacists working in one sector can cause acute shortages in other sectors. While we welcome and support the development of pharmacy roles in general practice, through the Additional Role Reimbursement Scheme (ARRS), these roles have contributed to acute shortages in community and hospital sectors in some localities. A joined-up approach to workforce across the system should help to address these challenges, especially as the NHS LTWP supports the expansion of ARRS numbers.

16. Investment is needed to train new pharmacy staff and upskill existing members of the team, matching skills to tasks. Career pathways, supported by credentialing, should continue to be developed and adopted to make all roles more attractive and rewarding, allowing all staff to develop and work to the top of their competence and ability. Clear competency-based career pathways for post-registration professional development aligned to the RPS curricula for foundation[7], advanced[8] and consultant credentialing[9] should be used to support pharmacists' development and professional leadership.
17. Despite their essential role in the NHS, pharmacists in community pharmacy must still pay for their own professional indemnity, compared with pharmacists directly employed by the NHS, general practitioners and others whose costs are covered centrally. This siloed approach creates inequity between health professions and is incompatible with creating an integrated workforce. We would welcome the Committee's inquiry into pharmacy exploring whether current indemnity arrangements adequately support the ambition of an enhanced role for community pharmacy to supporting patient care.

18. As we look to develop an adaptable and flexible workforce, pharmacists should be able to access consistent and quality-assured professional development wherever they work. Workforce planning must include time for appropriate rest breaks, both for the welfare of pharmacists and for patient safety. With increased clinical roles, pharmacists must have

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[6] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/
[7] https://www.rpharms.com/recognition/all-our-campaigns/shaping-the-future-of-pharmacy-education/foundation-framework
[8] https://www.rpharms.com/resources/frameworks/advanced-pharmacy-framework-apf
[9] https://www.rpharms.com/development/credentialing/consultant

dedicated protected learning time within working hours[10]. Protected learning time should be equitable for all health professions, including those supporting primary care. Pharmacy teams must be supported to enable them to benefit from flexible working and portfolio career options. Enabling pharmacists to work in different settings allows access to pharmacists with the right skills at the right time regardless of setting.

Integrated Care Systems (ICS)

19. ICSs should support the collation of robust workforce data to provide intelligence nationally and to help determine the workforce required to deliver population health. They should implement new ways of using the pharmacy workforce, developing a whole profession approach to strategic workforce development across an ICS that recognises the full contribution that is possible from pharmacy. This could include:
    - Rotational roles across historical working boundaries.
    - Using the independent prescribing workforce, with clear modelling of how this can be used across healthcare settings. As all pharmacy graduates will be independent prescribers ICSs will need to consider how best these skills can be utilised across systems
    - Career progression across primary and secondary care, for example the development of consultant pharmacists for the frail elderly population working across the system.
    - Innovative clinical services across primary care to enhance collaboration and integration.
    - A Chief Pharmacist in each system to provide leadership and oversight to the development of the workforce across the system.

Workforce Wellbeing

20. We believe that it is more important than ever to support the pharmacy workforce so that the staff needed to deliver patient care now and into the future can be recruited, trained and retained. Improving the retention of staff in the profession is an important part of solving the current workforce challenges. Our latest Workforce Wellbeing Survey with independent charity Pharmacist Support showed that burnout remains a key issue facing the workforce in every sector, with many respondents considering leaving their current role or leaving the profession.[11] The survey also showed that inadequate staffing cited by 70% of respondents as the leading factor for poor mental health in the pharmacy workforce.

21. Workforce planning must support pharmacy and the whole of the health and care workforce, backed by investment in education and training. Key steps to support staff retention include:
    - Adequate staffing and rest breaks to support staff welfare and patient safety.
    - Equal access to staff wellbeing services, including national and ICS-led programmes.
    - Equitable protected time for learning, research, and service development.[12] A pilot on protected learning time was launched in Wales in 2021 but we are yet to see a similar commitment in England.[13]

Hospital Pharmacy

22. As demand for pharmacist expertise increases, the Government and NHS should re-energise investment in hospitals to implement the Carter Review recommendations[14], creating capacity for hospital pharmacists to spend more time on clinical services, patient safety and supporting colleagues in primary care and other settings. A further review published in 2020[15] also highlighted the importance of supporting the training and development of the aseptic pharmacy service workforce across England. Aseptic pharmacy services played a crucial role

[10] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/protected-learning-time
[11] https://www.rpharms.com/recognition/all-our-campaigns/workforce-wellbeing
[12] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/protected-learning-time
[13] https://pharmaceutical-journal.com/article/news/protected-development-time-pilot-to-take-on-30-community-pharmacists-and-technicians
[14] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/931195/aseptic-pharmacy.pdf

during the COVID-19 pandemic and will be even more important as we move towards individualised treatments in the field of gene therapies, advanced therapies and point of care manufacture. Pharmacists, supported by pharmacy technicians, will be central to providing the technical, logistical and governance expertise for these innovative products.

Prescribing

23. A quarter of the pharmacists on the GPhC register have an independent prescribing annotation, and prescribing will be possible for all new pharmacists at the point of registration from 2026. Any workforce strategy must support and harness the skills of pharmacist independent prescribers in clinical care, including:
    - Investment in training, both for new and existing workforce
    - Access to supervisors.
    - Protected learning and development time.
    - Commissioning of services to make best use of independent prescribers across care settings, supported by appropriate prescribing budgets in community pharmacy.

24. Consideration needs to be given as to how to make pharmacy roles more accessible, ensuring a strong and diverse pipeline to better reflect the communities we serve. This work must include all roles within the pharmacy team, ensuring a strong skill mix for future service provision.

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

25. The short answer to this question is that digital systems in these different care settings are not joined up at all. There are some local exceptions, where local commissioners have taken measures to ensure that information is shared across different care settings. For example, in Dorset, community pharmacists have access to a patient's Shared Care Record (ShCR)[16].
26. Better system integration will need the digital infrastructure to support it. A Quality by Design approach should be utilised with a Quality Management System to ensure the impact is assessed, risks identified, mitigations applied and systematic review occurs. Pharmacists in community settings have historically had very limited ability to update a clinical record when they treat a patient. The COVID-19 vaccination programme has highlighted the urgent need to ensure a more integrated approach for health professionals across care settings. Nationally, IT solutions have been put in place to enable the transfer of information about flu vaccinations between community pharmacies and GP practices to make sure this information is on a patient's record and this needs to be developed for future services. However, these solutions are limited in scope and miss the opportunity presented by full records access.

27. There needs to be significant national investment in general practice and community pharmacy systems to enable seamless integration and exchange of clinical information for incorporation into the patient medical record as required. Investment is required in IT to ensure that any pharmacy offering services has access to the National Care Records Service and additionally to ICB-level shared care records, so that information from pharmacy systems can be shared to those records and pharmacists have access to the GP care record where that provides necessary access to information.

28. A clear roadmap and timeline around complete read and write access to medical notes for community pharmacy is needed. While there are signs of progress in the primary care recovery plan, more needs to be done sooner to make shared care record access a reality across the country. This will ensure further integration of community pharmacy across the NHS and enable better continuity of care for patients.

[16] https://news.dorsetcouncil.gov.uk/dorset-care-record/2022/03/02/how-a-community-pharmacist-uses-the-dorset-care-record-during-the-week/#more-1863

29. There are no national solutions to enable referral between GP and community pharmacies, in either direction. When the Community Pharmacy Consultation Service (CPCS) was established, IT solutions were put in place. RPS joint report with the RCGP[17] found that these were clunky systems and GPs were reluctant to use them due to the time it took to enter the information. One of our recommendations was an ask for additional investment in local system project management support and resources to drive CPCS implementation as well as streamlining referral pathways to make it easier for patients and staff. Transfer of information between care settings continues to be challenging. There needs to be support available to develop easier general practice referral / triage functionality and interoperability with community pharmacy IT systems, so that all members of the general practice teams or patients who wish to make an appointment are diverted to an appropriate appointment type, with an appropriate person, at an appropriate time. The service referral pathway also needs to be streamlined through the use of e-consultation platforms/algorithms to triage a patient and refer them to community pharmacies from general practice. The investment in the digital infrastructure in community pharmacy continues to be very limited.

30. The Discharge Medicines Service is a welcome move to enhance patient outcomes, collaborative working and reduce the burden on GPs. This is an essential service for community pharmacy contractors to ensure better communication of changes to a patient's medication when they leave hospital and to reduce incidences of avoidable harm caused by medicines. By referring patients to community pharmacy on discharge with information about medication changes made in hospital, community pharmacy can support patients to improve outcomes, prevent harm and reduce readmissions[18]. However, implementation is not yet consistent across the country and would benefit from funded digital platforms in all parts of the system. The available data shows a significant variance in the number of DMS referrals made by acute trusts. Further efforts to drive consistency in approach and service delivery would aid this ambition being met. Digital solutions are required. The Health Committee's Expert Panel has already commented on the challenges in digital transformation[19].

31. If we are to better manage demand across the health service, making the most of the whole of the workforce in primary care, pharmacists who are providing care to patients must have read and write access to a clinical record, wherever they may work. This is a long-awaited enabler for pharmacists in community settings to better utilise their clinical skills and improve patient safety. While work is underway to enable Shared Care Records in community pharmacy, there should be a renewed sense of urgency across Government and the NHS to deliver this.

32. As well as enabling community pharmacists to update a clinical record about a patient's care, better data collection would help shape local population health approaches alongside quality improvement and research to support prevention.

33. NHS Care Identity (e.g., the current NHS Smartcards and future virtual NHS care identities) and NHSmail accounts should be simple to access. Those pharmacists and pharmacy technicians that are registered by the General Pharmaceutical Council (GPhC) should be granted an NHSmail account for their use so long as they remain on the GPhC register. This would involve some data sharing agreementsto be developed between GPhC, NHSE's Transformation Directorate including NHSmail team and local Smartcard Registration Authorities (RAs). At present obtaining Smartcards and NHSmail involves a duplicative process in which the pharmacy professional must submit the same information separately to multiples bodies to receive the NHSmail and NHS Care Identity necessary for their work This is a burdensome process and means pharmacy professionals experience delay in being able to provide patient care.

[17] www.rpharms.com/recognition/all-our-campaigns/policy-a-z/cpcs
[18] www.england.nhs.uk/primary-care/pharmacy/nhs-discharge-medicines-service
[19] https://committees.parliament.uk/publications/33979/documents/186799/default/

34. Pharmacists will also have a role in helping with clinical informatics and shaping local population health approaches alongside quality improvement and research.

35. Greater use of electronic prescribing can support prevention by reducing prescribing errors. However, it has been reported that the roll-out of electronic prescribing and medicines administration systems in secondary care is taking longer than expected, with concerns that the resulting 'hybrid' systems might create risks to patient safety.[20]

36. The implementation of electronic prescribing systems within NHS Trusts is varied, and associated with many challenges.[21] Electronic prescribing in hospitals is not universal. 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. In addition to this, some Trusts have multiple paper prescription charts in use across the Trust alongside the electronic prescribing system (approximately 70 different types of paper prescription charts) for items such as fluids and complex infusions. Barriers to eliminating these paper charts relate mainly to resource, for example, the functionality / module is available in the electronic prescribing software for complex infusion prescribing and administration, but resource in terms of equipment, staff, funding and IT infrastructure have hindered implementation.

37. Currently, homecare services require a 'wet' signature which prohibits electronic prescribing, and delays medications reaching patients. Electronic prescribing systems in secondary care settings need to be able and ready to incorporate transfer to homecare provider companies.

38. There is a commitment within NHS Trusts to achieve a reduction in paper prescribing, but it is very unlikely that this will be achieved within the next year. This is due to a number of factors.
    - Funding available to achieve interoperability across all prescribing interfaces, also systems have not been designed to achieve the Information standard DAPB4013 or see any obligation to achieve this without charging considerable development fees.
    - Functionality of systems available to achieve paperless prescribing in outpatients, ward attenders, treatment centres due to systems functionality being designed to meet standard in-patient prescribing only.
    - Expertise of staff and available informatic pharmacy staff to configure the systems to achieve this.

39. There needs to be a step change in how we implement technology, both within organisations and across the wider healthcare system, because the current approach does not engage with the workforce and this is creating barriers, a disconnect and resistance to patients that will benefit from it.

40. Digital literacy can also be an issue, and this should be incorporated into the formative training for healthcare professionals.

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

41. The biggest single innovation in pharmacy that would create a change in pharmacy services is full read and write access to a patients' clinical record in all care settings.

42. With growing numbers of people living with long-term and often multiple conditions, the Government and NHS should also explore how community pharmacists could support the

[20] https://pharmaceutical-journal.com/article/feature/competing-priorities-why-is-the-rollout-of-e-prescribing-taking-so-long
[21] https://committees.parliament.uk/publications/33979/documents/186799/default/

management of long-term conditions outside of general practice.[22] With the right support, community pharmacies could be used routinely by the public as easily accessible 'health hubs', for example, for women's health, sexual health, minor illnesses, monitoring of long-term conditions and administration of medicines.

43. In future, pharmacy teams should be able to enhance opportunities for early detection of ill health through interventions that use population health data and maximise ongoing advances in technology, such as wearables and point of care testing. Pharmacy teams should also be able to link seamlessly into services, such as, social prescribing, social care, housing and the voluntary sector. Pharmacy involvement in delivery of clinical trials in secondary care has provided an opportunity for this model to also be used in community pharmacy.
44. Our work with The King's Fund highlighted how pharmacy teams should be supported to work with communities to design culturally competent and tailored approaches to healthcare delivery that enable action on the wider determinants of health. Pharmacists can do much around health inequalities, supporting the work of CORE20Plus5.

45. There is a personalised medicines revolution coming in the next decade. The development and application of pharmacogenomics (PGx) in clinical practice is an expanding area in healthcare which aligns with national and NHS priorities across Great Britain. As technology improves and costs reduce, we will have better and faster access to genetic information to help tailor treatment to individual patients. Pharmacists are medicines experts with a background of scientific training and are therefore well equipped to play an integral part in the development of PGx. From system leadership to implementation of services, pharmacists can tailor and personalise the prescribing of medicines based on genetic information. There are many benefits of PGx, including reduced time to patient therapeutic response, increased patient safety, reduced adverse effects of medicines and reducing pressures on healthcare systems. It is vital that the pharmacy workforce is prepared and builds the knowledge and skills required to confidently lead and support at the forefront of PGx.

46. As an example of this Dihydropyridine Dehydrogenase (DPYD) testing is widely used within clinical practice across all UK nations. The DPYD test determines whether a patient has a DPD enzyme deficiency resulting in an inability to breakdown fluoropyrimidine based chemotherapy. The implementation of DPYD testing has enabled the routine screening of all cancer patients eligible for treatment with fluoropyrimidine-based chemotherapy, enabling appropriate dose modifications or complete avoidance. This significantly improves patient safety, reducing side effects and decreasing hospitalisations and even death[23].

47. If we are to develop innovative approaches to patient care within an Integrated Care System, working across primary and secondary care settings, pharmacy must be included alongside other partners in the decision-making processes.

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

48. RPS continues to call for fair funding in the longer-term to help pharmacies keep their doors open to the public. It is important that the funding structure supports a resilient network that provides appropriate access for patients and the public. Recent analysis of pharmacy closures shows that there were more than five times as many closures in health deprived areas compared with the number of closures in the least deprived areas[24]. This indicates that the current funding model is no longer working to support the most disadvantaged in society.

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[22] www.rpharms.com/resources/reports/making-a-difference-for-people-with-ltcs

[23] Owusu-Obeng A, Weitzel K.W, Hatton R.C., et al. Emerging roles for pharmacists in clinical implementation of pharmacogenomics. Pharmacotherapy. 2014;34(10):1102-1112. DOI:10.1002/phar.1481.

[24] https://pharmaceutical-journal.com/article/feature/catastrophic-implications-how-pharmacy-closures-widen-health-inequalitie

49. In community pharmacy, funding arrangements have signalled a shift toward more clinical service delivery, with pharmacy teams initially focused on minor illness, and the prevention and detection of ill health and supporting safe transition from acute to primary care services. This needs to continue. With the right support, and utilisation of robust Quality Management Systems, community pharmacies could be used routinely by the public as easily accessible 'health hubs', for example, for women's health, sexual health, minor illnesses, monitoring of long-term conditions and administration of medicines.

50. There has not been a sufficient shift in the emphasis on service delivery and the Community Pharmacy Contractual Framework (CPCF) remains focused on dispensing and the supply of medications. Around 2.9% of the national funding for the CPCF is spent on clinical services (2021/22). This is expected to grow to 4.4% (2022/23) and then over 6% (2023/24). This contrasts with the 2021 pharmacy contract in Wales, for example, which set out to accelerate the redistribution of funding to support aspirations for the wider availability of clinical services from all pharmacies.[25]

51. There must be a radical shift in the contractual framework to support direct patient care instead of medicines supply. While there were welcome steps outlined in the Delivery plan for recovering access to primary care[26], there needs to be a renewed commitment from the Government and NHS for an enhanced clinical role for community pharmacists.

52. They should explore the opportunity for pharmacists to be paid on patient outcomes. Some pharmacy contractors have chosen not to expand services (e.g. contraceptive services) due to the perverse incentives within the contractual framework[27]. The community pharmacy network provides patients with immediate access to the NHS, which must be backed by adequate support. A Taskforce for Lung Health survey of people with lung disease found that 86% of respondents felt there were more services that community pharmacies could offer[28].

53. Services offered by community pharmacies are inconsistent across the country, creating a postcode lottery. While a 'Pharmacy First' service from community pharmacies in England is a positive step and will support a more consistent service for the public this announcement was made outside of the CPCF as part of the Delivery plan for recovering access to primary care (the Primary Care Recovery Plan) and fails to address the underlying challenges faced in the CPCF itself which has been insufficiently impact assessed to understand the risks to date.

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

54. There are a range of factors that cause medicines shortages, and there is no single identifiable cause. Root cause analysis of shortages is challenging due to the complexity of the pharmaceutical sector and the multifactorial inputs into medication procurement,[29] Pharmaceutical supply chains involve multiple stakeholders, often with different procedural steps occurring in multiple countries and/or locations. Review of Marketing Authorisations and variations to Marketing Authorisations must have quick turnaround times to ensure continued and new medicine supply.

55. Nevertheless, in general, shortages may be broadly categorised by those considered as arising from factors that increase demand (such as in the case of COVID-19 increasing demand, formulary and prescribing practice changes, discontinuation of products from the market, procurement issues, regulatory issues, commercial affordability decisions, driven my

[25] https://www.gov.wales/sites/default/files/publications/2021-12/a-new-prescription-the-future-of-community-pharmacy-in-wales.pdf
[26] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[27] https://www.chemistanddruggist.co.uk/CD136973/Day-Lewis-halts-pharmacy-contraception-service-until-funding-progress-made?utm_source=sfmc&utm_medium=email&utm_campaign=2023_02_28_CDDail
[28] https://psnc.org.uk/our-news/pharmacy-services-a-lifeline-for-people-with-lung-conditions/
[29] https://www.fda.gov/media/131130/download FDA 2019

contracting practices) or factors that limit or reduce supply (quality manufacturing issues insufficient quantities of raw materials, trade changes, geo-political conflicts such as Ukraine and natural disasters). In combination these factors are leading to an increasingly fragile pharmaceutical supply chain.

56. Pharmacists and GPs are having to spend increasing time dealing with medicines shortages, with community pharmacists legally obliged to contact prescribers or refer people back to prescribers to amend original prescriptions, even for minor adjustments. This is frustrating for the patient, pharmacist and prescriber. The process can cause significant delays in patient access to medicines and take up valuable health professionals' time.[30]

57. The introduction of Serious Shortage Protocols in 2019 aimed to mitigate the impact of serious national shortages in certain medicines. It enables community pharmacists in the UK to supply a medicine against the protocol. The protocol can authorise a supply of a different formulation, strength and/or quantity of medicine. Consistent and widespread feedback from our members suggests that SSPs are bureaucratic, professionally frustrating and inflexible. They are not supporting continuity of care or minimising the burden across the healthcare system as intended. A more pragmatic approach is required.

58. Effort to reduce bureaucracy in general practice should include enabling pharmacists to make minor changes to prescriptions when a medicine is in short supply. This would improve patients' experience of care, empower pharmacists to use their expertise, and allow GPs to focus their time where it's needed most.

59. Government could support pharmacists to deal more effectively with medicines shortages by making the required changes in legislation as suggested by RPS policy[31].

60. To improve patient access to medicines and to mitigate the negative effects the medicines shortages, legislation should be amended to allow pharmacists to make minor amendments without a protocol. Amendments would include changes to as:

    - Different quantity
    - Different strength
    - Different formulation
    - Generic version of the same medicine (generic substitution).

61. Such substitutions have been standard routine practice for pharmacists in secondary care for years and are used in Scotland for medicines on the recognised shortages list. Similarly, in Wales the All-Wales Pharmacist Enabling and Therapeutic Switch Policy enables pharmacists, to make certain changes to prescriptions without contacting the prescriber.

62. Solutions should take into account flexible plans for returning, re-use and storage of medicines and the possibility that supply of these medicines will become increasingly difficult. One location where medication use could be improved is in in care homes. A 2016 RPS roundtable called for a named pharmacist and a named general practitioner to be responsible for medicines in each care home ensuring standards of care[32]. This would help support the safe and effective reuse of medication in care home settings.

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

[30] www.rpharms.com/recognition/all-our-campaigns/policy-a-z/shortage-policy
[31] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/shortage-policy
[32] https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Publications/Care%20Homes%20Round%20Table%20Report.pdf

63. The Primary Care Recovery Plan sets out significant investment in the community pharmacy sector. However, community pharmacists and community pharmacy teams like most healthcare professionals, are dealing with high levels of workplace pressure and burnout. Community pharmacy requires an increase in the workforce to support the delivery of this plan. This increase must come from the investments that are described in the NHS Long Term Workforce Plan.

64. For all additional clinical services commissioned through community pharmacies there needs to be investment in support for implementation, streamlining referral pathways to make it easier for patients and staff, and engagement and communications to drive uptake.

65. Access to digitally interoperable systems is vital. DHSC need to ensure that the IT systems are easy to use and integrate with current systems being used in community pharmacies. The IT needs to be interoperable with primary care systems so information can easily be transferred between community pharmacies and GPs. There needs to be continued long term investment in this area.

66. If pharmacists are required to undertake additional training for the delivery of this service, the time to undertake this training should be protected and pharmacist should be funded by commissioners to be able to train within their working day.

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

67. Access to community pharmacies is vital for communities. Research shows that there are 1.4 fewer full-time equivalent GPs per 10,000 patients in the most deprived areas than in the least deprived areas[33]. However, this does not apply to community pharmacy. This makes community pharmacy one of the most easily accessible healthcare providers in the NHS. Community pharmacy in England is accessible to the public, with 80% of people a 20-minute walk away from one, and twice as many located in deprived areas.

68. Researchers at the University of Durham[34] outlined the 'positive pharmacy care law', meaning people living in deprived areas have greater access to pharmacy services compared with those living in more affluent parts of the country.

69. Research conducted by The Pharmaceutical Journal found that pharmacies in parts of the country with high levels of 'health deprivation and disability' make 1.5 times the number of claims to the NHS for carrying out a contractual service. Between October 202[35]1 and September 2022, on average, pharmacies in the top 10% most health-deprived areas of England made 401 claims to NHS BSA for carrying out services such as the Community Pharmacist Consultation Service (CPCS) and the NHS Discharge Medicine Service (NHS DMS). This is compared with 266 such claims, on average, from pharmacies located in the 10% most healthy areas.

70. These services are vital in deprived areas, where people have been found to face multiple health problems more than a decade earlier[36] than those living in affluent areas and are more likely to have to manage prescriptions for ten or more different medicines[37] in at least one month of the year.

[33] https://www.cam.ac.uk/research/news/worsening-gp-shortages-in-disadvantaged-areas-likely-to-widen-health-inequalities
[34] https://bmjopen.bmj.com/content/4/8/e005764
[35] https://pharmaceutical-journal.com/article/news/pharmacies-in-englands-most-deprived-areas-provide-50-more-nhs-services-to-their-local-populations
[36] https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity
[37] https://nhsbsa-data-analytics.shinyapps.io/healthcare-inequalities-nhs-prescribing-and-exemption-schemes/

71. It is important that the funding structure supports a resilient network that provides appropriate access for patients and the public. Recent analysis of pharmacy closures shows that there were more than five times as many closures in health deprived areas compared with the number of closures in the least deprived areas[38]. This indicates that the current funding model is no longer working to support the most disadvantaged in society.

72. Current workforce challenges have exacerbated the challenges in some areas, and further consideration needs to be given to the assessment of pharmaceutical needs in each locality, led by the ICS.

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

73. Further development of the commissioning arrangements for community pharmacy is needed. There is a need for agreement at national level about how community pharmacy fits with the broader primary care strategy, removing some of the elements of current approaches where resources are moved between community pharmacy and general practice.

74. We believe that primary care contracts across all professions should be aligned. Currently the contracts across the different primary care providers, especially general practice and community pharmacy, promote competition rather than collaboration between professionals and this impacts on service delivery for the local population. A clear example in this area is the perverse competition related to vaccination policy that creates tension between primary care providers. With the delegation of commissioning to ICBs, NHS England has a responsibility to review primary care contracts and ensure that they are aligned to support truly integrated working at a system level. There should be consideration of incentives to facilitate local-level collaboration (e.g, support to free up pharmacy and GP time to come together to identify local issues where working together could deliver value-based care).

75. We have welcomed efforts to support general practice and align work across primary care, such as through the PCN contract and Directed Enhanced Services. However, as we look ahead to the NHS recovery, there is still a need to consider primary care more holistically, managing workforce, workload and funding, so that the system improves as a whole. PCNs are somewhat limited by contracting and administration requirements and could have been better enabled to allow more innovative approaches to commissioning support from community pharmacy. Given the state of preparedness within ICBs, the approach to further local commissioning of services in pharmacies is likely to be limited. There is a need for capacity and capability in commissioning at national level.

76. With growing numbers of people living with long-term and often multiple conditions, the Government and NHS should also explore how community pharmacists could support the management of long-term conditions outside of general practice.[39] Once a patient has been diagnosed with a long-term condition and stabilised, ongoing support should be provided by an appropriate multidisciplinary team to provide patient-centred, integrated care. Commissioning approaches will need to consider the complete patient pathway, utilise a Quality by Design approach, and as such will require simple systems for referring between elements of primary care to avoid patients feeling ‘bounced’ around different elements of the system.

77. The contract for the delivery of community pharmacy services will need to be revisited. This should enable all pharmacies to be able to offer a wide range of services that will need to be nationally specified and priced to ensure consistent availability in all locations.

[38] https://pharmaceutical-journal.com/article/feature/catastrophic-implications-how-pharmacy-closures-widen-health-inequalities
[39] www.rpharms.com/resources/reports/making-a-difference-for-people-with-ltcs

78. Pharmacies should ideally be able to opt to do more than this, in agreement with their local commissioners, drawing from a nationally agreed menu of additional services and to develop and agree other additional services to meet local needs.

79. Community pharmacies have a significant role to play in terms of the delivery of public health services[40]. They deliver a range of public health services through the Healthy Living Pharmacy (HLP) framework[41], including substance misuse management, smoking cessation, alcohol intervention, weight management, contraception and emergency hormonal contraception, and vaccination services. We know that patients are comfortable and happy with the service provided by Healthy Living Pharmacies and these services reduce the need for GP appointments. The community pharmacy network requires further investment in the commissioning of public health services from pharmacies. The announcement to deliver oral contraception and the detection of high blood pressure services from community pharmacies as part of the Primary Care Recovery Plan[42] is welcome.

80. We believe that a national offer that is provided by all pharmacies will be understandable to the public and may also avoid the frustration of people and patients being turned away from services.

[40]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf
[41] https://www.gov.uk/government/publications/healthy-living-pharmacy-level-1-quality-criteria
[42] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/