NHS Confederation

Pharmacy

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About us

The NHS Confederation is the membership organisation that speaks for the whole healthcare system in England, Wales, and Northern Ireland. Our members employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care, and reducing health inequalities.

Executive Summary

The health and care system faces long-term challenges which are driving increasing waiting times, putting pressure on NHS staff and adding strain on the public purse.

Against this, resources need to be efficiently utilised across the system. The pandemic has emphasised the vital role that pharmacies can play in our local communities and the enormous amount of clinical expertise they have, with scope for greater involvement.

Identifying more ways to integrate pharmacy services with the wider system and exploring how pharmacists can get more involved in discussions about healthcare planning is key to meeting the growing needs of local populations.

The sector also needs support with recruitment and retention, significant investment in the estate and a long-term funding settlement which is robust enough to deal with changing economic circumstances, or we risk losing an asset that bucks the inverse care law[1].

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

1. Pharmacy is now so much more than just medicine. Pharmacists have been part of general practice for ma years and there are new pharmacy roles in Primary Care Networks (PCNs) that are contributing towards transforming services across systems. However, there remains variation in the level of their involvement.

2. Integrating pharmacy is therefore key. As of April 2023, responsibility for commissioning pharmacy was delegated to integrated care boards (ICBs), with the hope that the move would achieve such integration. Delegation is just the start, however. The future of pharmacy should be one where the sector has an equal say in decision-making as other partners in the system, which the government should empower systems to address.

[1] https://www.kingsfund.org.uk/publications/articles/inverse-care-law

3. Any vision needs to look at digital infrastructure to enable more collaborative and integration. In acute trusts, pharmacists based in hospitals still have poor communication systems. This could be resolved through improving digital systems which allow pharmacy services to work on patient requests quickly. In primary care, there remains a lack of effective IT interoperability between general practice and community pharmacy which slows down processes. For example, most practices operate on either EMIS of SystemOne whereas most pharmacies operate on Pinnacle PharmOutcomes or Sonar Informatics. This does not necessarily prevent the sharing of information, but it does slow it down and make it more complicated. More broadly, the intersection between secondary and primary care pharmacy is an important area for consideration and one which is let down by insufficient technology.

4. Pharmacies are also ideally placed to support a wider shift to population health management (PHM). However, this will require support and incentivisation to enter local and national partnerships regarding data sharing, particularly around understanding social determinants of health such as employment and housing data, which are crucial to a PHM approach.

5. From an estates perspective, community pharmacy is often highly accessible to patients, making a considerable contribution to health on the high-street, but it does not always benefit from broader NHS capital investment programmes. The future needs to include pharmacy as part of multi-service health and care facilities, including the shared use of estates. By tackling the wider determinants of health and enhancing social prescribing activities, pharmacies can be effective community anchors and hubs of health creation.

6. Perhaps most importantly, this vision cannot be achieved without support from the government. This should include funding that supports integration and new infrastructure to plug the £750 million per year funding gap[2] as well as long-term training opportunities to grow and retain the workforce. More investment needs to go towards the innovative services that pharmacy is uniquely placed to lead on such as pharmacogenomics, electronic ordering systems, and home delivery systems.

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

7. The pharmacy workforce is made up of highly skilled and qualified health practitioners with a high degree of public trust, with nine in ten patients reporting positive experiences of community pharmacy[3]. However, a combination of factors has meant that the workforce faces significant pressures in recruitment, training, professional development, and retention.

    a. **Demand:** A surge in patient demand has put pressure on the workforce. For example, since the start of the COVID-19 pandemic, 31 per cent of people are more likely to visit a pharmacy first before seeking help elsewhere, there is therefore huge potential for the sector to help reduce pressure elsewhere in the system[4]. Developments outlined in the General Practice Access Recovery Plan are welcome, such as expanding oral contraception (OC) and blood pressure (BP) services as well as allowing pharmacies to prescribe

[2] https://thecca.org.uk/funding-gap-in-england-equates-to-more-than-67000-per-pharmacy/
[3] https://www.england.nhs.uk/2022/12/nine-in-ten-patients-positive-about-nhs-community-pharmacies/
[4] https://pharmaceutical-journal.com/article/news/nearly-a-third-of-people-more-likely-to-visit-theirpharmacy-first-following-covid-19-pandemic

antibiotics, but they need to be matched with appropriate funding and investment which covers the increased cost of service delivery. This includes paying staff wages, covering the rising cost of bills, and – in some cases – the cost of home delivery schemes[4].

b. **Workforce burnout:** A 2022 survey found that 91 per cent of pharmacies were experiencing staff shortages, and 82 per cent reported that pressures were negatively impacting the mental health of staff[5]. New technology can support in reducing overall workload, but it needs to be matched with leadership and management support, as well as a fulfilling career path to inspire and retain the workforce.

c. **Cross sector recruitment**: PCNs have offered skilled pharmacists the opportunity to work in different environments. Whilst they play a crucial role in tackling health inequalities, there is a risk that resources are being moved away from community and secondary care services that are also under pressure, not least as the role of the pharmacy technician, which is expected to growth significantly, as outlined in the NHS Long Term Workforce Plan[6]. As also highlighted in the Plan, a system wide workforce plan to facilitate skills sharing and work placements would help alleviate pressures.

8. **Training and development**: Education reforms mean that newly qualified pharmacists will become prescribers from 2026. This is a welcome move towards acknowledging their clinical skillset and redistributing resource away from general practice. However, there needs to be the appropriate infrastructure in place at a national and system level to ensure sufficient training and development exists for both newly qualified pharmacists to make the most out of their new powers, and for existing pharmacists to be encouraged to become prescribers too. Increasingly, the contribution that the pharmacy sector provides is being recognised. But to maximise its full potential, funding needs to keep up with demand which hasn't been the case.

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

9. The current digital systems in community pharmacy are poorly integrated with general practice, with communication between the two sectors largely dependent on NHS Mail. Interoperability of technology, digital systems and data is a continuing challenge and evident across the entirety of the NHS. A PHM approach may help with segmentation and stratification of underserved populations by delivering equitable access to everyone, but this will rely on IT systems having the right functionality.

10. Improving Application Programming Interfaces (API) Integration between the existing clinical systems and payment systems operational in Community Pharmacies would be a welcome start.

[4] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[5] https://bmjopen.bmj.com/content/4/8/e005764
[6] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

11. Further investment has been mentioned in the PharmacyFirst scheme and API Integration appears to be a priority in the General Practice Access Recovery Plan which is welcome[7][8].

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

12. Pharmacy is increasingly capable of providing a wide range of clinical services.

13. Some effective innovations taking place in Pharmacy include:

    a. Extending the community pharmacist consultation service to direct GP referrals for minor ailments such as bites and stings, cold and flu symptoms, and general muscular pain.

    b. Pharmacogenomics: Pharmacy can be central in delivering personalised medicine and improving the diagnosis pathways because it has the capacity and competency to play a significant role in the development of pharmacogenomics.

    c. Electronic ordering systems to make it more convenient for patients to access their medications and streamline the patient journey. This also allows pharmacists to amend prescriptions more easily. The system already exists in secondary pharmacy and in all pharmacy settings in Scotland.

    d. Home delivery. While pharmacy is typically very accessible, the home delivery of medication would add another dimension to the personalisation of care and increase patient choice of how they receive their medicines.

    e. Innovations from an acute perspective are FP10 prescriptions[9] – hospitals are now starting to source these in certain outpatient settings to allow patients to take prescriptions to their local pharmacy.

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

14. The five-year funding settlement for community pharmacy comes to an end in March 2024. The deal has allowed for the expansion of several important services such as blood pressure checks and the Smoking Cessation Service (2022), which in turn have helped redistribute demand across primary care and away from general practice, freeing up time, resource, and expertise in other parts of the system.

15. During this time, however, community pharmacy has come under increasing financial pressure, partly because of rising inflation This has had real-life consequences. For example, the hourly cost of a Locum Pharmacy Manager has more than doubled in England in the last few years; the role can be expected to reach £60 per hour, while 80 per cent of practices are running higher costs than the previous year.

[7] https://www.england.nhs.uk/2023/05/patients-to-benefit-from-faster-more-convenient-care-undermajor-new-gp-access-recovery-plan/
[8] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[9] FP10 prescriptions are purchased by NHS organisations including Hospital Trusts and are distributed free of charge to medical and non-medical prescribers, NHS dentists and other organisations as required.

16. This has been compounded by rising costs relating to wages and running pharmacies. Stakeholders have reported of pharmacies cutting their staff by 15 per cent while still having their costs increase of more than £4,000 per month[10]. A fixed funding formula is therefore clearly not suitable to contend with this rapidly changing landscape.

17. Additional funding commitments for community pharmacy have been welcome, such as the £645 million investment which was announced earlier this year as part of the Common Ailment Scheme, and the Pharmacy Integration Programme, which offers the sector an opportunity to access further funding for innovative pieces of work[11][12].

18. As demand for community pharmacy is expected to increase, the cost of running these services is unlikely to fall, highlighting the importance of future sustainable funding[13]. It should be long-term, while accounting for change in the face of unexpected economic changes such as high levels of inflation. Otherwise, the benefits community pharmacy can bring to primary care are at risk.

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

19. Ensuring an adequate supply of medicines requires a delicate balance between fluctuating (and sometimes unpredictable) demand and availability. Even in "normal" times there are shortages, sometimes caused by a spike in demand for certain medicines or by an interruption in supply. Recently, there have been severe and obvious additional pressures caused by factors such as Covid-19 and the war in Ukraine which has affected transportation routes[14].

20. There is a recognition that even in "normal" times the global supply chain relies too heavily on China, which manufactures a very high proportion of the world's pharmaceutical ingredients, and India, which manufactures the finished products and is the major world supplier of medicines.

21. Heavy reliance on a limited number of sources is unwise, especially given current geopolitical tensions with China and introduces vulnerability into the supply chain. European countries, including the UK, are recognising the need to diversify their supply chains. This may involve "onshoring" the manufacture of medicinal products and producing them in our own countries, or "friendshoring" by obtaining supplies from countries with whom we have good relations.

22. "Onshoring" requires making the UK an attractive place to develop and manufacture pharmaceuticals and to attract inward investment for innovation, which is a major plank of the government's recent "Life Sciences for Growth" strategy[15].

[10] Information sourced from an interview that was conducted by the NHS Confederation with a pharmacist on 23 March 2023.
[11] https://www.england.nhs.uk/2023/05/patients-to-benefit-from-faster-more-convenient-care-undermajor-new-gp-access-recovery-plan/
[12] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/
[13] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[14] https://www.nuffieldtrust.org.uk/research/health-and-brexit-six-years-on
[15] https://www.gov.uk/government/news/chancellor-reveals-life-sciences-growth-package-to-fire-upeconomy

23. In the UK, a great deal was learnt during the period after the Brexit referendum when, for a couple of years, there was uncertainty about whether a deal would be reached with the EU and considerations about what this might mean for essential supplies.

24. NHS England has developed robust systems for stock control, including stockpiling and warehousing of essential items and a resilience preparedness system for escalating concerns which stood the UK in good stead for medicines supplies during the pandemic.

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

25. The General Practice Access Recovery Plan sets up the potential to transform pharmacy within primary care. It is estimated this could save 10 million appointments in general practice per year[16].

26. While several common health conditions that the plan encourages pharmacy to treat are already treated in pharmacies including sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated UTIs in women, it also details a wider transformation in the way community pharmacy engages with patients. Support to increase capacity within the sector is needed to fully realise this.

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

27. There are over 11,000 pharmacies across England, and community pharmacies are highly accessible, with 90 per cent of the population within 20 minutes of a community pharmacy, rising to 99 per cent in deprived areas[17][18].

28. This speaks to two key assets of sector; community pharmacies are well positioned to improve access to health services as they are often positioned on local high streets or accessible via a car, public transport, or by foot, and their ability to target treatment in the most deprived areas.

29. The location of community pharmacies makes it easy for the public to seek rapid advice and support for their condition or medication. This is particularly important for people with a mental health condition, who may have misguided concerns about the medicines they need to take regularly or issues with potential side-effects.

30. It remains important that community pharmacy is accessible, particularly to the most vulnerable and deprived patients, if the sector wants to continue to address the inverse care law.

31. However, it should be noted that rural pharmacies are acutely exposed to workforce shortages, as they find it harder to recruit staff, with access for patients also being another issue due to limited public transport connections. When designing national policy to support community pharmacy, special attention should be paid to community pharmacies who are experiencing specific problems pertaining to their rurality.

[16] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care2/#building-capacity
[17] https://questions-statements.parliament.uk/written-questions/detail/2022-07-20/40982/
[18] https://cpe.org.uk/learn-more-about-community-pharmacy/the-value-of-pharmacy/

32. To mediate this risk, 13 per cent of general practice surgeries nationally dispense medicines[19], but in rural areas – where the running costs of pharmacies are even higher – dispensing practices are sometimes the only way patients can access medicines. Targeted supported for rural pharmacies to allow them too to dispense medicine would therefore not only improve patient access but also take pressure off general practice.

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

33. Delegation of community pharmacy commissioning to ICBs presents an opportunity to bring local community pharmacy leaders together with other local stakeholders to redesign and improve services.

34. Realism is needed on the timescales for when this can happen: While the first year of delegation will largely deal with 'on boarding' functions from NHS England's regional teams, opportunities will emerge when functions have been properly transitioned and ICBs are given time to strengthen relationships with providers.

35. However, as the NHS Confederation found in our report which assessed key learnings from the nine Integrated Care Systems who took on pharmacy commissioning nine months early, ICBs need to be empowered to make improvements[20]:

    a. **Agency**: Delegation of formal functions is just the start of enabling local transformation. NHS England should seek to empower systems as much as possible with the flexibility to take new approaches and innovate. Central support should focus on building ICBs' capacity and intelligence without being too prescriptive.

    b. **Governance**: While robust governance is essential to ensuring the quality and safety of services commissioned, governance requirements should be proportionate, so they do not consume excessive capacity. NHS England should seek to further streamline governance requirements around transition, so systems can spend more time planning and designing service transformation work.

    c. **Data**: Most importantly, timely and sufficient data, together with the capability and capacity to analyse it, is essential to strategic commissioning, enabling ICBs to identify unmet need in their populations and ensure the quality of services. Some pharmacy groups have their own systems for generating data, whether individually as a collective of local pharmacy committees, or as a group of companies. In other areas, health systems have data systems in place, but in some areas, data generation is less well developed. Early adopters of delegated community pharmacy commissioning felt they need improved access and ability to analyse data. NHS England should support ICBs to access and analyse data from different sources to identify population need and oversee service quality.

[19] https://www.chemistanddruggist.co.uk/CD005119/Do-rural-dispensing-doctors-have-a-prescribingconflict-of-interest
[20] https://www.nhsconfed.org/publications/delegation-integration