Response

Health and Social Care Committee Inquiry
Department's White Paper on health and social care

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About the Company Chemists' Association (CCA)

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

Executive Summary

We welcome the broad aim in the White Paper to improve collaboration and integration across the health system to deliver better care for the population. We believe that delivering more seamless and joined up care will bring benefits for the NHS, healthcare professionals, and patients.

Community pharmacies are an essential part of primary care and provide clinical services, supporting urgent care, prevention and providing care in the community, as well as dispensing over a billion NHS prescription items each year. The network of over 11,000 community pharmacies presents considerable untapped potential to deliver care upstream in local health systems, close to patients' homes.

We hope that the proposals in the White Paper will create an environment that allows the community pharmacy sector to do more and support the rest of the NHS. To enable this, community pharmacy must be imbedded into ICS structures, so that pathways, systems, and funding can be used to align priorities and ensure better outcomes for patients.

Response

Working together to integrate care

The CCA believes that the NHS' current statutory structure, which aimed to introduce competition and patient choice to drive improvement, has not worked. We therefore welcome the Government's shift in focus from competition to collaboration.

However, significant improvements in how different health settings collaborate will not be achieved solely through legislative change. There is a strong reliance on the nature of the relationships currently in place in local areas, which have been exacerbated by ingrained patient behaviours and designed pathways. There is a risk that without truly joint working, previous strong priorities will overwhelm other partners, leading to gaps in provision and potential health inequalities. Therefore, clarity is needed on the remits and responsibilities of all partners to avoid any conflicts, gaps in care, or duplication of effort.

To ensure that the Government's aim to bring together all health and social care providers is met, it is crucial that all organisations who contribute to health and care are engaged. This must include community pharmacies and their local representative bodies – Local Pharmaceutical Committees (LPCs). There must be mandatory inclusion of local representative bodies such as LMCs, LDCs, LOCs and LPCs within the ICS governance structures. No one group, or profession should hold a majority position for decisions made in any system.

We recognise the importance of ensuring services are commissioned to meet the unique health and wellbeing needs of a local population. However, we strongly oppose any move to transfer commissioning of all national services to a more localised level. Locally commissioning some services, that are currently commissioned centrally by NHS England & Improvement, will lead to inefficiencies in the system and could also exacerbate health inequalities.

Community pharmacies are commissioned by NHSEI, via the Community Pharmacy Contractual Framework, to provide essential and advanced services such as the supply of medicines. People need medicines regardless of where they are (similarly they need flu jabs). Such national level contractual agreements mean that patients can receive the same high-quality care wherever they are in England. To introduce a system where regional variances could emerge would impact significantly on the quality and equity of care provision.

We do see, however, value in supplementary care over and above a core that meets a specific local need. This currently sits primarily with CCGs and there is value in ICSs being able to use their scale and system level oversight to commission more effectively. New ICSs present an opportunity for rationalising services across larger boundaries, recognising the common needs of populations while responding to specific local priorities. We see a clear role for NHS England and the NHS Regions in ensuring that there is no unnecessary duplication of effort by ICSs, coordinating delivery of specialist services, supporting mutual aid, and overseeing research and innovation projects. This would also provide clear national accountability through the Regions to the NHS England Board and to Parliament.

Finally, we welcome the broad aim to improve data sharing. We have long called for the creation and implementation of nationally agreed data standards. This will facilitate the sharing of information seamlessly across settings, so healthcare professionals have access to relevant information to support patient care. More clarity is needed on how these new powers introduced for the Secretary of State will lead to the system-wide change that is required.

Reducing bureaucracy

We welcome the aim set out in the White Paper to remove unnecessary bureaucracy in the health and care system. The response to the Covid-19 pandemic has led to some long-standing barriers being overcome, including some temporary changes to overly bureaucratic processes in community pharmacy. We would encourage the NHS and the Government to carefully consider any temporary changes implemented during the Covid-19 response that should be made permanent to ensure the health system is fit for the future. There is an opportunity to build on the lessons learnt during the pandemic, rather than merely resorting back to old ways of working.

In our response to the DHSC consultation on reducing bureaucracy in the health and social care system, we highlighted many examples of unnecessary bureaucracy inflicted on the community pharmacy sector. This includes collecting considerable amounts of data for the NHS without a clear purpose, and undertaking administrative tasks that do not benefit patients, or the system. We called for reports and processes to always be designed with a 'digital first' approach to reduce unnecessary manual tasks for healthcare professionals and reduce the need for paper exercises and wet signatures. To prevent outdated processes accumulating we also recommended that all activities should be regularly reviewed and removed from regulations if they do not directly contribute to patient care.

Again, legislative change alone will not bring about the desired outcomes for removing bureaucracy across the health and care system. We therefore call upon DHSC and the NHS to work with healthcare providers and their representative bodies to fully understand the barriers and co-create solutions.

Enhancing public confidence and accountability

Like other sectors in the health and care system, community pharmacy is facing significant challenges recruiting and retaining staff. Data from the General Pharmaceutical Council shows that between 2011/12 and 2016/17 applications to study at UK Schools of Pharmacy fell by 30%.

As well as this reduction in the pipeline of future pharmacists, recruitment challenges are particularly severe in community pharmacy as some staff are drawn to PCNs and other primary care-based roles.

However, despite these new roles attracting more interest, the severity of the overall pharmacy workforce shortages was highlighted by reports that almost a quarter of PCNs had not claimed the NHS funding for recruiting a PCN Pharmacist[i]. While these figures cannot be solely attributed to workforce shortages, local leaders have highlighted the recruitment challenges they face.

We welcome the proposal in the White Paper that the Secretary of State will be made accountable to Parliament to report on the work undertaken to address the health and social care workforce crisis. It is essential that this reporting and planning takes account of all professionals who deliver NHS services for the public, including community pharmacy staff.

Additional measures

Community Pharmacy is well placed to support the NHS' aims around public health, particularly by providing healthcare services which support the prevention agenda. We believe that to achieve the best possible patient outcomes, public health commissioning should be led by the NHS. The new ICSs need to be accountable for delivering upstream public health services to reduce the burden on the system and deliver care in the community to support people to live healthier lives.

Conclusion

We support the shift in focus from competition to collaboration and integration. We believe that delivering more joined up care across the health and care system will benefit the NHS, healthcare professionals, and the public. However, legislation alone cannot bring about improvements in how partners work collaboratively. We therefore call upon the Government to issue further clarity on the remits and responsibilities of all organisations providing care in the system.

Community pharmacy must be embedded into ICS structures so that the sector can support the rest of the NHS to deliver seamless, joined up care.

[i] https://pharmaceutical-journal.com/article/news/nearly-a-quarter-of-pcns-did-not-claim-nhs-funding-to-hire-extra-pharmacists