Company Chemists' Association Response

Public Accounts Committee

Call for Evidence: Rollout of the COVID-19 Vaccination Programme

March 2022

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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. Our membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate over 6,000 pharmacies, which represents nearly half the market. Our members deliver a broad range of healthcare and wellbeing services, from a variety of locations and settings, as well as dispensing over 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. Our vision is that everyone, everywhere, can benefit from world class healthcare and wellbeing services provided by their community pharmacy.

Executive Summary

We welcome the Committee's call for evidence into the rollout of the COVID-19 vaccination programme.

Our response offers the experiences and perspectives from the community pharmacy sector in the distribution and uptake of COVID-19 vaccines in England. High street pharmacies often serve as the first point of healthcare contact for many people. They are therefore vital to community engagement, identifying those eligible for vaccination and understanding specific population health-based needs. Throughout the pandemic pharmacies cemented their position as key frontline healthcare professionals at the heart of their communities.

Figures from the rollout clearly indicate these strengths displayed by the community pharmacy sector in the delivery and distribution of the Covid-19 vaccination. Together with GPs, we have administered 71% of vaccines against an initial planning prediction of 56%. Further, community pharmacy teams administered 185,000 booster jabs in a single day in December 2021 - 44% of all booster jabs on that day.[i] More data up from that period shows that, up to and including 9th December 2021, 16.7m Covid vaccines had been administered by community pharmacies in England, 17% of all vaccines to date and 32% of the PCN total.

In our response, we propose several key recommendations to further maximise community pharmacy's frontline impact in the national drive to vaccinate the population against Covid-19:

- **Addressing issues regional variation amongst providers** – We would like to see a move from competition to collaboration by embedding more streamlined and standardised processes.
- **Harnessing the full range of skills and abilities within the sector** - Adding pharmacy technicians to a list of healthcare professionals who can administer the Covid-19 vaccine via patient group directions (PGDs) would ease pressures on pharmacist staff and utilise core skills across the sector.
- **Increasing patient recruitment and vaccine uptake** – Community pharmacy has a unique position in identifying and understanding local population needs to increase patient recruitment.
- **Establishing better and more streamlined data recording and performance evaluation** – Moving beyond inconsistent or ad-hoc recording towards infrastructure that enhances digital interoperability.
- **Transitioning to a business-as-usual delivery model** – The CCA calls for a sustainable and uniform vaccine service to be commissioned that meets public health needs in the long-term.

Response

1. Regional Variation in Rollout

Designation Process

In the first instance, pharmacy colleagues have reported that the designation and expression of interest (EOI) processes were particularly labour intensive, causing added stress and delay to the rollout for no meaningful benefit. Our members considered the multiple on-site assurance visits to be repetitive and the role of on the ground teams such as Local Pharmaceutical Committees (LPCs) to be unclear.

These difficulties point to significant regional variations in guidance, communication, and information, leading to uncertainty in decision-making. For example, variations in the local interpretation of national guidance (e.g. the assurance processes for sites for 12–15-year-olds) led to some regions requiring a physical visit whilst other areas only requiring self-declaration. Our members have expressed concerns regarding the designation processes by region, which had different formats and variations in spreadsheets and timelines, yet all of which asked for effectively the same information.

Further, points of contact have provided varying support across the country and unfortunately information was not always forthcoming. A preference for email communication caused delays, particularly during emergencies. We are aware of instances of not being able to receive consumables and being asked to source them locally. There have been different requirements for anaphylaxis kits (if the NHS did not have these available as part of the site inventory list), one area suggested using the kit in place for flu, another area required a specialised kit which could not be sourced in the timeframe, thereby postponing the clinic.

In addition to inconsistencies in guidance and communication, teams experienced variation in support for IT hardware provision and connectivity. The third phase of the rollout saw minimal support in place for sites with lower capacity, whereas sites delivering medium to higher levels of capacity were given support as per the Local Enhanced Service Specification process.

From Competition to Collaboration

Planning and implementation of the programme's phases initially created counterproductive silos and tensions between providers with the potential to negatively impact throughput and uptake. There is evidence from our members to suggest commissioners giving preferential treatment to some contractors.

The CCA has previously welcomed the Government's shift from competition to collaboration between providers as part of the Integrated Care White Paper. There is therefore a key opportunity to integrate community pharmacy into the wider primary care team. Community pharmacy and other parts of primary care should work collaboratively to support the wider NHS.

Community pharmacy holds a unique position in addressing local needs whilst delivering national health services. Whilst we want to see this shift to better collaboration, we oppose any move to transfer commissioning of national services to a more localised level if it results in increased variation. We want to see commissioning at a national level where local implementation can support this.

Embedding more streamlined and standardised services avoids disparities in local commissioning and guidance to ensure all patients and communities receive the same level of high-quality service when receiving a dose or booster of the Covid-19 vaccination.

This is particularly true for reducing the care and treatment backlog since there is an urgent need to think more holistically about where resources are deployed in the healthcare system. Acute services and GPs should not need to divert further resources away to focus on the vaccination programme as the backlog of care continues to grow. Unlike many other parts of the NHS, community pharmacy operates according to a different contractual framework with the majority of 'normal' business completed during the pandemic.

This positions community pharmacy as a unique healthcare provider with a very limited backlog that has the capacity to deliver additional services. By using community pharmacy as a default option for vaccinations, this eases the burden on other parts of the NHS and effectively prioritises and delegates care for patients.

2. Workforce Challenges

Rethinking Engagement

Community pharmacy has played a pivotal role during the pandemic in the face of unprecedented demand. Where other providers may have moved the bulk of services online or limited appointments, community pharmacy has continued to offer a physical source of trusted advice and care for local communities, whilst adapting to quicky evolving public health needs and legislation. To meet these surges in demand, there have nonetheless been sustained pressures upon community pharmacy teams, further driven by certain areas of the COVID-19 vaccination programme and increased levels of hostility from the general public.

We would like to see more sustainable plans in place for the sector's workforce as the programme moves into the post-peak phase. Ongoing issues such as supply and continues to add pressure on professionals across the NHS and healthcare sector, with pharmacy being no exception. We need to recognise the significant workforce challenges ahead both in the immediate and long-term.

To that end, it is worth reconsidering reliance on volunteers and good-will. Volunteers have been integral to the rollout of the Covid-19 vaccines and continue to offer an incredible degree of support. The community pharmacy sector has engaged extensively with thousands of volunteers across its premises and off-site locations to provide additional support to our teams.

Whilst engaging with volunteers has been invaluable to the initial stages of the rollout, and indeed there is the potential to utilise volunteers in future programmes, we need to consider how a transition to a more sustainable delivery model suited to future trends and demands could better attract and retain colleagues in the community pharmacy sector. This model cannot rely on volunteers alone on a longer-term basis. In delivering a national service, allocating formal responsibilities to those without formal employment arrangements adds a degree of operational complexity and liability.

Further, it leaves the continuity and quality of a service open to unpredictability and inconsistency. Research from the King's Fund suggests that the lifting of the furlough scheme impacted volunteer numbers, with many returning to work.[ii]

Holistic Workforce Planning

Part of this delivery model should factor in holistic and long-term workforce planning for pharmacy teams to meet and anticipate patient needs. Capacity constraints and a lack of confidence to invest will impact on pharmacies' ability to deliver on the NHS's vision for the future of the sector.

This presents a key opportunity to utilise and evolve the range of skills available from across community pharmacy teams. Pharmacy teams consist of a diverse and adept workforce. Going forward, we would propose that their full skills and capacities are further harnessed. We urge the Government to commit to including pharmacy technicians on the list of healthcare professionals able to administer vaccinations under a patient group direction's (PGDs). This would present vital short-term additional support so that pharmacists can deliver further clinical services across England amid the pressures of the pandemic, facilitate a longer-term step change that enhances this important career pathway in frontline healthcare. Outdated legislation currently limits the already valuable role of pharmacy technicians within their teams.

This would entail only a small technical legal change with no cost burden to the Government or the NHS in making this change. The CCA recognises that whilst the National Protocol is useful, the benefit is nowhere near as significant as adding pharmacy technicians to PGDs would be. One problem with the protocol route is that governance processes or frameworks are in place for the PGD supply of medicine and there remains uncertainty about the long-term future of the protocol (and

subsequently the Covid-19 vaccination programme) which impacts decisions to design new processes.

We are concerned that whilst pharmacists have provided a high-level of frontline care and services under the Community Pharmacy Contractual Framework (CPCF) and delivered the Covid-19 vaccination programme, the General Medical Services (GMS) contract has allowed for an acceptable reduction in care. An interpretation of guidance from the General Pharmaceutical Council (GPhC) of the role of registered pharmacists indicates it would be difficult for registered pharmacists supervising the delivery of the day-to-day CPCF to also supervise the running of a vaccination clinic under the national protocol. More precisely, registered pharmacists must oversee the running of the vaccination clinic, meaning that non-pharmacist clinical leads for pharmacy sites could be best placed in overseeing these other areas.

Logistically, we believe that national protocols work best in large sites with multiple vaccination lanes; many pharmacy sites have fewer lanes (often due to the pharmacy space). Community pharmacies have offered a more cost-effective alternative to larger sites, with vaccination centres as the most expensive model at £34 per dose compared with £24 for GPs and pharmacies. To continue with a high-quality programme that is economically sound, we believe it would be more efficient to provide the service via a PGD. In turn, this will maximise skillsets and training opportunities across pharmacy teams services to mitigate and ease workload pressures across the primary care sector.

The enhancement of these skills should be aligned with increased opportunities and the commissioning of services to allow colleagues to use their wide-ranging abilities. Without such efforts there are risks that colleagues will leave the sector in favour of a setting where they can use enhanced skills, leading to further workforce problems across the wider healthcare sector.

3. Access and Uptake

Patient Recruitment

We believe that the national booking system, supported by the national invitation, has generally worked well. Experience from the community pharmacy coalface suggests that although 'Did Not Attends' (DNAs) have been a constant problem (alleviated somewhat by walk ins) volumes have been high and consistent. The earlier stages of the rollout directed different patient cohorts to different providers, leading to confusion amongst patients. Local booking systems used in parallel by (often) GP surgeries led to a share of these difficulties. Many missed appointments were due to patients being booked in multiple locations and not cancelling appointments.

Whilst this has been addressed in subsequent invitations and reminders from the NHS Digital's national messaging service, offering patients a more comprehensive menu of providers, we recognise that critical to the long-term efficiency is ensuring either all providers use a single booking system or all booking systems are integrated and linked. However, using pre-booking slots alone should not be a required step - walk-in models, especially encouraged through the 'evergreen' offer, are best placed to ensure those with hesitancy or time constraints are able to be vaccinated.

Rather than relying on GP patient lists and activity alone, uptake could be improved by directing different patient groups with specific needs to different healthcare providers, allowing for more tailored patient recruitment. Community pharmacy has a particular advantage in that pharmacy teams are well placed to carry out opportunistic interventions. High street pharmacies are highly accessible and indeed are part of, and operate in, the heart of communities, meaning that teams have a strong understanding of local population needs.

Overcoming Disparities

In that vein, there needs to be a clearer representation of the breadth of expanded services provided by community pharmacies, including vaccination, through better communication efforts. Vaccine hesitancy and lower uptake rates amongst certain populations has and continues to present a key challenge. A recent report from the NAO shows that up to and on 31 October 2021, 75% of those living in the 10% most deprived communities had received two doses of a COVID-19 vaccine,

compared with 94% of those in the 10% least deprived communities. Figures also point to the variation amongst ethnic groups, with those from Black Caribbean, Black Other or Chinese backgrounds less likely to be vaccinated against Covid-19 compared with their White counterparts.[iii]

Concerns around public messaging, misinformation and longstanding mistrust toward health services have all to varying extents contributed to lower uptakes amongst underserved cohorts. The location and accessibility of bricks and mortar community pharmacies have long presented those from underserved groups with trusted frontline healthcare support.

Our pharmacy colleagues have therefore been able to address some of these issues surrounding uptake– particularly amongst these communities – and vaccine hesitancy through targeted action. For instance, pharmacies have been attentive to cultural and religious sensitivities by setting up offsite pop-up vaccination spots.

Since local variation in service specifications leads to an increased administrative burden for the NHS and providers, and by changing the care people receive in different parts of the country, this will inevitably lead to health inequalities. Teams across the sector already have a proven track record of supporting hard to reach groups; commissioning a standardised Covid-19 vaccination service via community pharmacy and including community pharmacies in national campaigns will help combat disparities in uptake.

4. Anticipating Need and Long-term Planning

Evaluating Performance and Capacity

Community pharmacies teams have found that reporting information and access to data was mostly helpful, but systems could be 'ad hoc' or inconsistent. For example, the number of patients booked was available but not their age cohort, how the locality was progressing through a cohort population, and what other sites were doing.

Monitoring current and future uptake rates and population health-based needs requires clearer and more accessible data. Contractors need a real-time understanding of how these rates are progressing to properly assess which aspects are delivering and where efforts should be redeployed to fully support priority patient groups. Data clarity allow contractors to enhance operational service management.

The Foundry system offered a useful method of monitoring and identifying gaps in uptake, but many community pharmacies have reported problems with gaining access to it, causing subsequent delays Ideally there would be fewer, more stream-lined systems, which would likely help with this.

Systems need better intercommunicability and need to fit within a digital infrastructure that is cost-effective to the NHS. NHSD/X should develop this infrastructure and national data sharing agreements to enhance digital interoperability, reducing the level of bureaucracy present in the vaccination programme.

Towards a 'Business-as-Usual' Model

Developing a robust 'pull' model is critical to allow contractors to plan workloads, manage local stocks and reduce the administration (and reliance) on NHSEI central teams. Initially the rollout of the Covid-19 programme operated according to a 'push' model based on a short-term mass vaccination programme with emergency arrangements in place. Since the need to 'stand up and stand down' with little to short notice causes significant inefficiencies in the rollout process and issues with supply, we recommend that a business-as-usual delivery is adopted, and a national public health strategy developed to address broader contingencies.

Currently, the transition from push to pull comes as confidence grows in the vaccine and the programme, which should allow greater operational freedom for providers that is important to ensuring contractor engagement, increasing volumes and throughput. Whilst community pharmacy teams have demonstrated agility in adapting, at short-notice, to demands associated with the programme, the sector requires greater certainty in the way of mid-to-longer-term planning as England enters the post-

peak phase of the pandemic, especially in providing for patients with high clinical risk and vulnerability.

In order to cater to priority groups and ensure business investment in the programme is secure, we would urge for more assurance on pending phases of the programme. The stepwise tiered method to scheduling vaccinations should be revaluated; we no longer need to have a rigid approach but instead would encourage a priority order within a 'pull' model.

For a seamless and smooth transition, we would like to see the Covid-19 vaccination come through normal supply chains and a removal of the designation process. Modifying or abandoning the designation process and making community pharmacy the default provider would be operationally smoother and more cost-effective for the NHS.

From this, we would recommend that the requirement and risk burden for the NHS to oversee professional standards and patient safety is instead moved to providers. Giving community pharmacists more autonomy will deliver better patient care, more flexible delivery of services and the ability to react to local needs in any crisis situation and any future spikes in the current pandemic. Some comparisons can be drawn with community pharmacy's delivery of flu immunisations and the internal governance used there, offering good practice examples to illustrate the potential of a similar Covid-19 vaccination service.

The associated costs with delivering the vaccine programme will reduce by moving to a business-as-usual mode. Ad hoc clinics and preparations for short-notice supply and distribution measures yield higher and sunk costs for providers. Moving beyond an emergency implemented programme to commissioning a national uniform service with community pharmacy as the default provider offers better value for money, prioritises population needs and effectively allocates NHS resources.

Conclusion and Summary of Recommendations

We welcome the Committee's timely call for evidence as England reaches its post-peak phase of the pandemic and consideration is given to longer-term planning of the Covid-19 vaccination programme.

Our submission offers the experiences of our colleagues to demonstrate that community pharmacy has the capacity to be the preferred provider within a properly commissioned, business-as-usual national vaccination service. We believe that the recommendations as outlined in our response will further untap this potential:

- **Addressing issues regional variation amongst providers** – We would like to see a move from competition to collaboration by embedding more streamlined and standardised processes.
- **Harnessing the full range of skills and abilities within the sector** - Adding pharmacy technicians to a list of healthcare professionals who can administer the Covid-19 vaccine via patient group directions (PGDs) would ease pressures on pharmacist staff and utilise core skills across the sector.
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- **Transitioning to a business-as-usual delivery model** – The CCA calls for a sustainable and uniform vaccine service to be commissioned that meets public health needs in the long-term.

[i] Royal Pharmaceutical Society response to NAO report (February 2022)
[ii] King's Fund (February 2022) 'The Covid-19 Vaccination Programme: Trials, Tribulations and Successes'
[iii] National Audit Office (February 2022) 'The Rollout of the Covid-19 Vaccination Programme in England'