Company Chemists’ Association

# Public Accounts Committee
## Managing the NHS Backlog and Waiting Times

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COMPANY CHEMISTS' ASSOCIATION

**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.

**Introduction and Executive Summary**

Community pharmacies serve as the first point of contact for many people, particularly underserved patient groups. [1] Throughout the pandemic, pharmacies continued to deliver vital frontline healthcare, dispensing over one billion medicines in England in 2021 whilst offering an expanded portfolio of clinical services for patients. Unlike many other healthcare providers during this period, pharmacies remained open and accessible to advise and support patients, with limited backlog.

We welcome this important opportunity to review the current progress of recovery plans. Our response highlights community pharmacy's central role in supporting the NHS with the backlog, manage waiting times, and release capacity in other parts of the health services. Making best use of the pharmacy workforce and their growing clinical expertise is essential, especially in public health and prevention. This is best achieved through standardisation of processes, digital access, and patient pathways.

In our response, we propose the following key recommendations to manage the backlog of care, supporting patients and the wider health system:

i. **Standardising Provision and Access to Care –** Policymakers must urgently tackle regional variation. Standardised care provision across the country should not be compromised under the new ICS landscape and delegated ICB functions. Our members can deliver vital healthcare at scale, alleviating the postcode lottery.

ii. **Effective Resource Deployment Across the Health Sector –** We strongly recommend an evaluation of how resources are deployed and commissioned across the NHS and its partners. Community pharmacy has demonstrated that it is a 'ready and willing' provider; commissioning a selection of public health services from community pharmacies (such as vaccinations) is crucial to releasing capacity elsewhere.

iii. **Holistic Workforce Planning –** The healthcare workforce is experiencing immense pressures. Policymakers should harness the full range of skills and abilities within the community pharmacy sector.

**Response**

### i. Improving and Standardising Access to Care

Although longstanding, the pandemic has brought the UK's worsening health inequalities into sharper relief. Community pharmacy already offers significant benefit to local populations, supporting with medicines optimisation and management, public health promotion, and the provision of an expanding range of clinical services. It is estimated that 89.2% of the population has access to a community pharmacy within a 20-minute walk. This rises to 99.8% for people in the most deprived areas.[2] Given its high accessibility in deprived neighbourhoods, community pharmacy bucks the inverse care law to deliver much needed public health interventions.

Community pharmacy presents a highly accessible healthcare venue in areas where non-communicable disease burden and the associated complex risk factors may be greater. For instance, deprivation has been linked to a greater risk of developing cardiovascular disease. The CCA found that the Community Pharmacy Hypertension Service, which launched last year, saw nearly 45% of blood pressure checks take place in areas of greater deprivation. This is a clear example of where preventative healthcare is appropriately harnessed to minimise patient risk and mitigate strains on the rest of the NHS.

As part of short to long term recovery plans, decision makers must be mindful of the sector's value in improving access to care. Unequal variation in local provision and access to strong primary care – particularly in less affluent parts of the country – has historically been associated with a knock-on impact on the rest of the NHS. This leaves providers unable to complete or manage episodes of care in the community, leading to reactive and costly specialist, acute or emergency care. More recent research from the King's Fund shows a clear link between longer waiting times and lists and areas of deprivation.[3]

However, chronic underfunding has resulted in a worrying trend of permanent pharmacy closures over the past seven years. Our research shows that England has lost 670 community pharmacies since 2015/16 – around one in twenty. [4] Of particular concern, our analysis reveals that over 40% of those closures took place in some of the most deprived neighbourhoods in England. Although a nationwide trend, there are regional pockets that have experienced higher pharmacy losses, concentrated in deprived areas around the North West, South East and the West Midlands.

Given pharmacy's accessibility across the country, a continued reduction to the community pharmacy network will add unmanageable strain on the rest of primary care and the wider NHS. If policymakers are serious about planning for preventative healthcare and mitigating strain on the health sector, we will need to see concerted and uplifted investment to community pharmacy, which has seen a real-terms decrease by around 25% since 2014. We also strongly recommend publication of the government's Primary Care Strategy as promised earlier this year.

Secondly, our members are able to deliver vital healthcare services at scale, improving access for patients across the country to tackle the postcode lottery faced by many. However, fragmented commissioning models and variation in service specifications frustrate this. We would like to see greater standardisation of services to address this regional variation. For example, standardising emergency hormonal contraception (EHC) through a national service in pharmacies is a recommended point of departure. Over the pandemic, many sexual health clinics were forced to close their doors, left with a growing backlog. A national EHC service could also move at least 70,000 GP EHC appointments, freeing up capacity here too and ensuring greater access to EHC for underserved communities.

Further, we note that variation in service designs and governance processes presents an unnecessary administrative burden for the NHS and providers. This must be acknowledged by

[2] Todd et al (2015) Access all areas? An area-level analysis of accessibility to general practice and community pharmacy services in England by urbanity and social deprivation: https://pubmed.ncbi.nlm.nih.gov/25956762/
[3] King's Fund (2021) Tackling the elective backlog – exploring the relationship between deprivation and waiting times: https://www.kingsfund.org.uk/blog/2021/09/elective-backlog-deprivation-waiting-times
[4] CCA (2022): https://thecca.org.uk/40-of-pharmacy-closures-in-last-seven-years-have-occurred-in-deprived-communities/

decision makers particularly in light of the new and evolving ICS landscape. For example, ICB delegation can result in regional variation and inconsistency in delivery, particularly for organisations crossing ICS boundaries. It is important that service protocols and clinical governance arrangements are defined nationally and implemented locally.

A key consideration here is the Discharge Medicines Service (DMS). Since 2021, community pharmacy teams have supported colleagues across primary and secondary care through the DMS. Around 30-70% of patients experience unintentional changes to their treatment when transferred from secondary to primary care. 20% of patients have been reported to experience adverse events within three weeks of discharge, 60% of which could have been ameliorated or avoided. Community pharmacy-led interventions upon discharge have been associated with a reduction in risk of hospital readmission.

As ICSs develop, it is important that there is consistency and integration in the necessary IT, digital and support systems to enable contractors to deliver at scale. Currently we are seeing significant regional variation in DMS service volumes, meaning that many patients have not realised the full benefits of DMS. Ensuring integrated digital pathways and frameworks are in place, this will enable pharmacy teams to support our colleagues in the NHS to reduce readmissions and improve patient outcomes.

### ii. Effective Resource Deployment

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 delivering certain services or interventions when community pharmacy is better placed as a preferred provider.

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, with limited backlog. Pharmacy’s offer of accessible ‘walk-in’ healthcare is an invaluable asset. The 2022 Pharmacy Advice Audit found that pharmacy teams in England provided more than 1.2 million consultations every week. Almost half of the patients reported that they would have gone to their GP instead, potentially resulting in 95 additional appointments per day per GP practice.[5] To continue to meet patient demand, and enhance community pharmacy’s offer, decision makers should consider pharmacies as a default option for a range of interventions.

Firstly, the Community Pharmacy Consultation Service (CPCS) has demonstrated that community pharmacists and their teams are well placed to advise and treat a variety of low acuity conditions Community pharmacies in England have been delivering the CPCS since 2019, with a GP pathway launched in 2020. In the last financial year, over 700,000 patients were provided support through the service.

CPCS offers an important start to safely transferring GP appointments to community pharmacy. There is a clear benefit to patients and the NHS through community pharmacy-led interventions for lower acuity conditions, yet it is currently being implemented with varying success. On the one hand, our research shows that around a third of CPCS consultations have taken place in the most deprived neighbourhoods, providing vital healthcare to improve population health. Indeed, the rollout of CPCS has further evidenced pharmacists and their teams’ clinical expertise to support patients with minor or common ailments, alleviating GPs from unnecessary appointments.

On the other hand, unnecessary bureaucracy – chiefly through the requirement for referrals and bulky data sharing infrastructure - acts as a bulwark to CPCS’s success. We support the development of Pharmacy First-style service, modelled similarly to the Scottish programme. Firstly, patients should have the option to self-refer to pharmacies to receive support for minor conditions. The current referral process into pharmacies adds unnecessary administrative burdens, including for providers referring patients into the service.

[5] Pharmacy Advice Audit (2022)

Further, to develop provider choice and pathways for patients, we would like to see the introduction of an independent prescribing PGD element to CPCS. From 2026 all new pharmacy graduates will be Independent Prescribers (IP), vastly increasing the breadth and acuity of treatment options available to them. There is a clear opportunity here to expand the scope of the CPCS to include an IP element and increase urgent care patient pathways. With additional funding and support this service could be expanded to wider patient groups, increased numbers, and greater levels of acuity, relieving pressure from GP colleagues and other healthcare providers.

Community pharmacy's role in vaccines is a second consideration for effective service deployment and planning. Commissioning recommended vaccinations from community pharmacy will allow GP colleagues to focus on other work. Pharmacy teams in England provide around 5 million influenza vaccines each year. In the National Audit Office's assessment of the Covid-19 vaccination programme, pharmacies had administered 71% of vaccines together with GP colleagues (based on the NAO report in February 2022). Previous CCA research indicates that in the first eleven months of the programme, over a third of community pharmacy-delivered vaccines were in the most deprived areas in England.

Where pharmacies are appropriately selected as the preferred provider of vaccine services, this could increase coverage and uptake. Community pharmacies can provide a further 10 million routine vaccines each year.[6] Users have reported strong user satisfaction when taking up community pharmacy-led immunisation services. Given that vaccine hesitancy still exists amongst many individuals and communities, it is notable that public trust in community pharmacy is high.[7]

Finally, as experts in medicines optimisation, community pharmacy can help prevent both further unplanned hospital admissions and readmissions. Research suggests that between 30 to 50% of medicines prescribed for long term conditions are not taken correctly. Non-adherence is a widely seen health problem for patients and a cost burden to the NHS. In England, adverse drug reactions cost the NHS £400 million each year and account for just over 6% of all hospital admissions.

Unplanned admissions under these circumstances can be avoided through effective medicines management in the community. Community pharmacy's New Medicines Service (NMS) is designed to provide medicines adherence support to patients with chronic or long-term conditions to safely manage their medicines. On average over 100 NMS claims were made by each pharmacy in England in 2021-22, equating to over 2million patients who were provided support through the service. Pharmacy teams are ready and willing to deliver more, which must be recognised by decision makers.

### iii. Holistic Workforce Planning

To deliver the above and manage the backlog, we strongly urge a holistic workforce plan to unlock community pharmacy's potential in the evolving NHS landscape. A significant challenge to ICS performance is both rising patient demand and capacity across all parts of the pharmacy and NHS network.

To ameliorate this, joint and strategic planning around workforce is crucial. It was disappointing to see that, under the Health and Care Act, there were no legislative duties announced to assess the state of the workforce on a regular basis. Given that ICSs currently have very little visibility or understanding of issues facing community pharmacy, there needs to be a parity of voice for effective and transparent workforce planning. We would recommend raising the profile of community pharmacy workforce pressures by ensuring fair representation on Integrated Care Boards and Partnerships and appropriate consultation, via Local Pharmaceutical Committees.

Pharmacies of all sizes are reporting increasing pressures and difficulties in the recruitment and retention of pharmacists. Factors such as changing working patters, increasing patient demand, high

[6] Analysis by the CCA suggests pharmacy programmes in other countries (USA, Canada, Portugal) deliver 60% of all primary care vaccines. This number is calculated based on this assumption and current primary care provision.
[7] Maidment et al (2021) Rapid realist review of the role community pharmacy in the public health response to COVID-19: https://bmjopen.bmj.com/content/11/6/e050043

vacancy rates, in addition to the continued recruitment of pharmacists in Primary Care Networks have led to capacity constraints.

To release capacity, we recommend that, in the first instance, the skills of the entire pharmacy workforce are harnessed. Pharmacy technicians should be included on the list of healthcare professionals who are able to administer vaccinations under a patient group direction (PGD). This entails only a small technical legal change; however, it provides vital additional support to optimise patient care.

As we have highlighted in relation to community pharmacist independent prescribers, there is an urgent need to develop the existing workforce, and then put in place the system to allow the use of these new skills. Whilst we welcome recent investment in training by the NHS and employers, this must be aligned with commissioning of services where these skills can be utilised. Without opportunities to utilise skills within community settings there is risk that colleagues with prescribing qualifications will leave the sector in favour of a setting where they can practice in line with their qualifications.

Harnessing the skillset of the pharmacy workforce would not only provide a clear argument for investment, paving the way for other clinical services, but it would improve professional satisfaction and support efforts to attract and retain team members.

**Conclusion**

To manage the backlog of care, our response has highlighted the following key recommendations that will unlock community pharmacy's potential whilst releasing capacity in other parts of the NHS:

i. **Standardising Provision and Access to Care –** Policymakers must urgently tackle regional variation. Standardised care provision across the country should not be compromised under new ICS/ICB commissioning functions. Our members can deliver vital healthcare at scale, alleviating the postcode lottery.

ii. **Effective Resource Deployment Across the Health Sector –** We strongly recommend an evaluation of how resources are deployed and commissioned across the NHS and its partners. Community pharmacy has demonstrated that it is a 'ready and willing' provider; selecting pharmacy as a preferred provider for services such as vaccinations is crucial to releasing capacity elsewhere.

iii. **Holistic Workforce Planning –** The healthcare workforce is experiencing immense pressures. Policymakers should harness the full range of skills and abilities within the community pharmacy sector.