Response to the letter "Community pharmacy in 2016/17 and beyond"

May 2016

Contact: Sue Sharpe
Chief Executive
sue.sharpe@psnc.org.uk
0203 1220 810

Pharmaceutical Services Negotiating Committee
Times House | 5 Bravingtons Walk | London N1 9AW

Summary

The letter of 17th December 2015 'Community Pharmacy in 2016/17 and beyond' ("the letter") addressed to the Chief Executive of PSNC and copied to other recipients, invited PSNC: "to enter discussions with the Department of Health, supported by NHS England, on changes to the community pharmacy contractual framework for 2016/17 and beyond, linked to the Spending Review".

In the period since last December most attention has been focussed on the reduction of funding that was set out in the letter and which throughout the period since publication of the letter we have been told is settled, or 'a done deal'. But that is by no means the only threatening or damaging element of the letter. Many other issues are raised and they combine to threaten the future of the current community pharmacy network and, as a consequence, patient access to pharmaceutical services.

In the five months that have passed since that letter PSNC has sought to understand, examine, analyse and test the Government's position on the issues raised in the letter. This has proved to be largely impossible. We have been thwarted by the lack of explanation and a reluctance to be forthcoming about Government policies that we have not encountered in the past. This has been, and remains, a profound obstacle to our ability to work collaboratively and constructively with the Government.

Whilst we have held discussions where we can, the paucity of information and material, inconsistencies in explanations and the Government's reluctance to be forthcoming about the underlying objectives have frustrated both us and our ability to negotiate.

Most significantly, we have been unable to obtain confirmation from the Government of the scale of closures of community pharmacies it wishes to achieve. Ministers and officials were explicit early in the discussions that they wanted to reduce pharmacy numbers, citing numbers as high as three thousand. Later in the consultation period the Government re-interpreted its policy, asserting that it had no agenda to close pharmacies although it recognised that pharmacies might close as a consequence of its policies.

We have been clear throughout that we are willing to work to agree a reshaping of the community pharmacy service - indeed this has been our policy for many years - including how we fund the sector. We are willing to extend this to discuss supporting a reduction in numbers where this could be done without detriment to patients' choice and access to pharmacy services. For this to happen it is imperative that there is a frank sharing of views and intentions, but regrettably the Government has not been willing to explain and discuss its objectives with us.

In the course of our discussions we have sought access to information and analysis that would help us to understand the anticipated cost savings associated with the plan to drive automated remote dispensing and a reduction in pharmacies. Officials have said informally that there is none.

We have put forward proposals that would protect and develop the community pharmacy service and its value for the NHS and communities. In response to these officials appeared to consider for the first time the potential increased demand on the NHS that would result were patients no longer able to rely on their local pharmacy for urgent supply when they run out of medicines or their local GP practice does not produce a repeat prescription promptly. This was a troubling illustration of the lack of attention that policies, even of this magnitude, seem to have been given.

The letter states: "The Government believes those efficiencies (i.e. the funding cut) can be made within community pharmacy without comprising (sic) the quality of services or public access to them". We have had no success in our efforts to find the information used to form this belief, and have concluded that there is none.

Many services, including extended hours of opening, home delivery services and supply of medicines in compliance aids, are provided voluntarily and free of charge by community pharmacies. If these are discontinued in response to

the reduced funding, they will add to the burdens and costs falling on other health and care services. It is quite extraordinary that, at a time when the NHS is seeking to reduce unnecessary use of expensive resources, it should adopt policies with a foreseeable consequence of increasing demand on these resources, without any inquiry or scrutiny of the likely impact. It is no wonder that many GPs have expressed dismay at the threat to close local pharmacies.

These threats to community pharmacies and the patients who rely on them are all the more worrying because they reflect a sudden and unexplained reversal of policy. A year ago, in May 2015, we had completed negotiations for a national flu vaccination service from community pharmacies and a national minor ailments advisory service, and were awaiting final confirmation. We had worked collaboratively and productively with the Government for more than twelve years to develop community pharmacy support for patients and the public. This had led to the introduction of Medicines Use Reviews, more recently targeted to ensure they gave best value to the NHS, and support services for patients newly prescribed medicines. We have put forward our proposals for using community pharmacists to relieve general practice of much of the routine care of millions of patients with long terms conditions, developing these services into care packages. We had invested in a robust, independently verified study of the cost benefits of specific pharmacy support services, with Department of Health and NHS England colleagues participating as members of the Steering Group. The results, presented to NHS England, were persuasive.

The direction of travel, and the value for the NHS that community pharmacy could offer, was not disputed. The problem, in a resource-starved NHS, was, we were led to believe, finding the funds needed to implement the new services. Then in June 2015 we were advised that NHS England no longer wished to pursue the minor ailments advisory service. No explanation for this change of direction was or has been forthcoming despite repeated requests.

The letter states that “we need a clinically focussed community pharmacy service”. No suggestions were made, in the letter or subsequently, by the Government about how this would be taken forward. We made our own proposals but these were not welcomed. In April we were advised of a review of pharmacies’ terms of service to be commissioned by the Chief Pharmaceutical Officer. The initial draft terms of reference for this and subsequent exchanges reinforced the picture of a reversal of policy, and an ambition to reduce community pharmacy services.

This sudden unexplained negativity towards community pharmacy coincided with an announcement by the Chief Executive of NHS England of a plan to employ pharmacists in GP practices, to assist general practice in managing the pressures it faces. This leads to suspicion that the policy reversal has been driven by an assumption that pharmacists working for GPs could and would replace the services and support provided by community pharmacies. If so, we believe it to be ill-founded, and again would want to see the evidence, or confirmation that none exists.

It has been made clear by ministers and civil servants that the proposed £170m funding cut is not negotiable, and we have faced a rejection of our proposals for alternative means of achieving savings. There has been no rationale for this and the apparent lack of consideration of the implications of other issues raised in the letter, which we have identified, must call into question the basis for the decision that this cut should be made. At the least, it has been made without any discernible sound assessment of the consequences.

We recognise the need for the NHS to find savings, and proposals we have made in the course of the last few months, albeit rejected, reflected our commitment, expressed to the minister last year, to help the NHS with its need for efficiencies. It is deeply regrettable that we have been met with intransigence, and an unshakeable resistance to harnessing the skills and expertise of our sector.

Working together, we could have used this as an opportunity to reshape the community pharmacy service, the funding delivery, and the market, to meet the needs of our patients and communities in future, delivering the care and support they need and want, and reducing costs for the NHS. It is vital, for the reasons we set out in this paper, that the Government works with us now to do this, and to do it properly.

Despite the frustrating and discouraging experience of the last year, we remain keen to engage in genuine and constructive negotiations, and to find ways to ensure that patients and the public get the very best support and care from a network of pharmacies, working within a reformed contractual framework designed to improve patient care, efficiency and value for the NHS. We wish to see funding delivery reformed to incentivise community pharmacies to provide the best possible care, and to remove those elements that lead to waste and avoidable costs. We want to participate, and use our skills and expertise in discussions that are informed and collaborative, characterised by openness and honesty.

Principles guiding our response

We set out in the sections below our views on the issues raised in the letter. We believe it is helpful to group these under the following principles:

- The interests of patients and patient care must underpin proposals
- Policies must be well-informed, using NHS resources effectively
- The ability of community pharmacy to offer much more to our communities has been largely neglected by policy makers. To meet the future health of our communities this must be properly addressed with urgency
- Remote supply and the benefits of automation are untested
- The interests of patient care must influence decisions about future pharmacy numbers and locations
- The NHS can make savings and improve patient care by developing patient services from pharmacies
- The government must be honest, open and fair in implementing a major change of policy on community pharmacy

1. THE INTERESTS OF PATIENTS AND PATIENT CARE MUST UNDERPIN PROPOSALS

Community pharmacies exist to support the patients and members of the public who use and need them. The viability of a community pharmacy is determined by the number of patients who use its services. Most community pharmacies are entirely dependent on NHS income for their survival; a Cost of Service Inquiry undertaken in 2009 by PricewaterhouseCoopers on behalf of the Department of Health and PSNC found that 85% of the turnover of a typical pharmacy (excluding the large health and beauty stores) came from the NHS. Changes since 2009 mean the average figure is closer to 90% NHS turnover today.

As community pharmacies today are overwhelmingly NHS businesses, we understand and accept that the NHS should determine what services it wants them to provide, and that it has a real interest in the location and costs of the community pharmacy network. It may review and revise its policies, but we expect that it will want to be careful in so doing to meet the needs and interests of patients, who must be at the heart of decisions.

Decisions on the future of community pharmacies should be guided by patients and an understanding of what they would like now and in future. They should take into account the growing pressures on health services, the need to encourage people to take more care of their own health, and the need to provide the care as cost-effectively as possible.

There is good evidence to support services encouraging people to use pharmacies first for advice on symptoms. A standardised advice service available to all patients across the country could change patient behaviours and help minimise unnecessary use of urgent care and GP consultations. Other well-evidenced studies show how development of community pharmacist consultations to review medicines use for specific cohorts of patients could reduce hospital admissions. In recent years pharmacies have changed their premises to provide facilities for confidential consultations with patients, and around 95% of pharmacies now have these consultation areas.

The Government consulted Healthwatch England, the national consumer champion in health and care, on the letter, as one of its wider stakeholders, and we have therefore been interested to read its recent Pharmacy Service briefing. The Healthwatch briefing concludes:

"From what the Healthwatch network has heard from people at both a national and local level, it is clear there is an appetite for pharmacy to play a greater role in preventing ill health, helping with minor concerns and supporting the management of long-term conditions.

- *The move to co-locate GPs and pharmacists makes sense from a consumer perspective, making services easier to access and enabling professionals to offer better joined up care.*
- *Similarly, the use of consultation booths in pharmacies could help promote the additional advice and support services that pharmacists can offer, and reduce pressure on other parts of the primary care system.*
- *The proposals made under the Pharmacy Integration Fund for Health Education England to place even greater focus on training the pharmacy workforce in its patient-facing role will help build on the positive relationship people already have with their pharmacist. This needs to go hand-in-hand with an awareness raising programme to promote what pharmacists can do for patients.*
- *Routinely involving pharmacists in medication reviews would improve use of their specialist expertise, ensure patients both understand their medication better and get the maximum benefit, and ultimately save money by reducing wastage.*
- *Technology can also improve continuity of care by enabling pharmacists to have access to patient records (where consent is granted) so they can be aware of an individual's wider health needs.*
- *Using the hub and spoke model to assemble personalised prescriptions is useful from a patient perspective, but it is important that people have accessible local services with the right expertise to address quickly any mistakes made in the process and provide additional advice and support where necessary.*
- *It is important to consider all user groups when trialling new ways of accessing services. Our work to date has made it clear that it is important not to make preconceived judgements about how certain groups may behave. For example, our research found that younger people were less in favour of Skype consultations than the over 65s, but that this was down to a lack of familiarity with using the health service rather than problems with the technology itself."*

It is evident from these conclusions that the national health and care consumer champion wants to see local community pharmacy services playing a greater role in health care, relieving pressures on general practice and providing even greater support to patients, using shared records and working more closely with, and as a partner in, the primary care team. We share their ambition but it is far from the picture of Government policy that has emerged from the letter and statements and discussions over the last few months.

2. POLICIES MUST BE WELL-INFORMED, USING NHS RESOURCES EFFECTIVELY

Decisions about healthcare should not be driven solely by the, admittedly acute, need for the NHS to find savings. In this case, doing so risks bad long-term decisions that add to costs and lead to unmanageable pressures on more expensive sources of care. The lack of any material reporting an examination of the impact of the pharmacy proposals strongly suggests that they are ill-informed and carry a real risk of major long term cost increases for the sake of relatively minor short term savings.

It is also important to examine critically the perception that clustering of pharmacies in some areas is indicative of a general over-funding of the service. Where a pharmacy closes, the service for its patients transfers to other pharmacies: the costs do not disappear.

The current market entry provisions specifically provide that decisions on applications to enter a pharmacy list have regard to the desirability of choice and therefore recognise that, where level of demand permit, it is good for patients to have more than one convenient pharmacy. If this policy is to change, it should be done following a proper process of consideration and consultation.

In order to ensure that patients get good quality, convenient and professional care to meet their health needs, decisions made by the NHS must be:

- Influenced by patients and users of pharmacies
- Clear and open about its policies
- Supported by analysis and assessment
- Compatible with wider health policy aims

Government and NHS community pharmacy policy, until the summer of 2015, was supportive of expanding the role of the sector, as we have already said. We have seen nothing to suggest that its change of approach was influenced by patients, supported by analysis, or is compatible with wider health policy aims.

Healthwatch begins its briefing:

"Our work over the last year has shown that the public are aware of the pressure the health and social care system is under and that they want to help.

Through our conversations and engagement with people we have learnt that there is huge potential for enhancing the role of pharmacies to create a more flexible, sustainable and consumer-focused primary care service."

3. THE ABILITY OF COMMUNITY PHARMACY TO OFFER MUCH MORE TO OUR COMMUNITIES HAS BEEN LARGELY NEGLECTED BY POLICY MAKERS. TO MEET THE FUTURE HEALTH OF OUR COMMUNITIES THIS MUST BE PROPERLY ADDRESSED WITH URGENCY

The unexplained apparent reversal of policy on a community pharmacy national Minor Ailments Advisory Service (MAAS) has never been explained and despite many requests, including a request made under the Freedom of Information Act more than five months ago that remains unanswered, we are unsighted on the process and rationale that led to the decision. This leads to a fear we believe to be well-grounded that there was no proper and informed consideration, but rather a hasty and ill-considered decision to remove planned investment in community pharmacy to fund NHS England's pharmacists in general practice pilot project.

We do not believe the pharmacist working in general practice will or can provide the support and care provided by community pharmacy. The risks and consequences of gaps in provision, and the adverse consequences for patients and other health and social care providers must be evaluated before decisions of such magnitude are made.

We have for many years been seeking to agree developments in NHS service commissioning that would increase the role of community pharmacies as clinical service providers. Until the recent policy reversal, this was an objective shared by NHS England, and before it handed over its responsibilities for service commissioning, the Department of Health. These have been set out for many years in PSNC's Vision and were supported by the sector. Progress towards our aims was impeded first by the recession and then by changes in NHS structures.

Healthwatch England recorded examples of using the community pharmacy service to improve patient care, including:

"In Portsmouth local Healthwatch have heard how the Rowland Pharmacy is working together with the Queen Alexandra Hospital to support newly discharged patients who have been identified as being at risk of readmission due to issues with their medication.

With the patient's permission, a pharmacist will visit their home within the first week of having been discharged and discuss with them how to take their medication, why they are taking it and take away any previous medication to avoid patients overdosing accidentally."

We recognise that implementation of changes to the services provided by community pharmacies requires change to the current structure of funding delivery, to remove perceived perverse incentives, and to drive quality and care. Our service development proposals address the need for change in funding delivery. The Government policy to simplify funding delivery by introducing a Single Activity Fee is a retrograde step. For several years we have worked with the NHS' stated ambition to move away from paying for units of activity, so this proposal was incomprehensible to us. In their negotiations with General Practice the Government has so clearly over the years recognised the need for funding systems to incentivise desired behaviours. By what logic would it seek to incentivise pharmacists by rewarding only units of dispensing?

A significant enabler of progress in optimising use of community pharmacy and proper integration of our service into primary care, is to provide relevant role-based access, with patient consent, to patients' health records. We have consistently pressed for this for more than ten years. We are encouraged that, at long last, small steps towards this are being taken, with the roll-out of access to the Summary Care Record. Even the very limited access this will provide will assist community pharmacies in reducing the need for reference to the GP to deal with patients presenting with problems. But this is slow progress and has impeded our efforts to enable community pharmacies to work more closely as part of the primary care team.

4. REMOTE SUPPLY AND BENEFITS OF AUTOMATION ARE UNTESTED

The letter indicates a determination to drive remote, automated supply services, bypassing the community pharmacy network for large numbers of patients. This policy is not, it seems, underpinned by any evaluation of how this change would affect patient adherence or outcomes, and this is foolhardy and dangerous. We are also struck by the absence of any evidence of cost savings. None has been produced and officials have acknowledged informally that there is none.

No evidence has been shared with us of which cohorts of patients would be expected or required to use remote dispensaries, or the benefits or disadvantages to them. And as a consequence we are concerned that their views have not been sought or given proper weight.

The Healthwatch England report says:

"Before any changes are made to local services it is vital that communities are consulted, in order to avoid creating confusing decisions that don't make sense to consumers."

A policy of reducing a substantial resource for providing care and supporting patients without careful assessment of the impact, and effective measures to address gaps in provision, cannot be wise; particularly so when that resource is the cheapest place for delivery of the care and support our communities need, and will continue to need as we face the burdens of older people living longer with increased incidence of long term conditions, and try to reduce the growth of avoidable, lifestyle-related disease.

There is some experience of online, remote pharmacy service provision in the UK, but it is not encouraging. In December 2015 the largest distance selling pharmacy had problems with its automated dispensing system and was

unable to supply patients' medication for a significant period. As a consequence community pharmacies reported a substantial increase in demands for emergency supplies of medicines at a time, immediately before the Christmas holidays, that made this very difficult to manage. The fragility of a system dependent on large remote service providers was highlighted by this experience. A few years ago the sudden closure of a pharmacy wholesale warehouse caused by extreme weather demonstrated what could happen to supplies if a remote dispensing pharmacy became unable to make deliveries. And it would be wrong to expect that a much reduced network of pharmacies could cope with the increased demand triggered by such an event.

The letter refers to the separate consultation on "Hub + Spoke", which appears to be seen by the Government principally as an enabler to drive the development of large-scale remote dispensaries. In examining that consultation we identified a serious inconsistency between the document and the accompanying draft regulations. The proposed regulation changes appear to be driven by the goal of automation, and do not include any assessment of whether there are other undesirable implications flowing from the regulatory changes. Once again, this is hasty and ill-considered. There is no basis for any confidence that the changes do not present a risk to patient safety.

The United Kingdom has a system of regulation of the supply chain of medicines that has meant we have had very low levels of counterfeit medicines entering the supply chain. In recent years greater controls on wholesale dealing have been implemented to further strengthen the security of our supply chain, and additional measures will be adopted in the next few years to implement the EU Falsified Medicines Directive. There must be a careful assessment of the potential for the proposed amendments to regulations to weaken some of the controls in place today. We make these points in our response to that consultation.

Most worrying is that the policy of driving a shift to large-scale automation has been founded on information, now admitted by the Chief Pharmaceutical Officer to be erroneous, of comparative safety between traditional and automated systems. The evidence he has cited for an error rate of three percent for traditional dispensing is founded on one small, controversial, uncorroborated study, several years old, reflecting systems and processes that have changed significantly in the years since the study. The Chief Pharmaceutical Officer even asserted that pharmacists had a professional duty to adopt automated dispensing systems. There is an urgent need to review how much of the policy was founded on there being a compelling patient safety ground that does not in fact exist.

5. THE INTERESTS OF PATIENT CARE MUST INFLUENCE DECISIONS ABOUT FUTURE PHARMACY NUMBERS AND LOCATIONS

Decisions about the number and location of pharmacies must be guided by the needs of patients and communities, and careful attention should be given to what patients and local communities want. We have seen no evidence in the last few months, or before then, that there is an unmet need for remote pharmacy services. Numbers of 'distance selling pharmacies' exist, a few operating nationally. Patients generally prefer to use a local pharmacy, where they can establish a relationship, sometimes quite a close one for patients with significant health needs, and they should not be pressured to accept a remote and impersonal service provider.

There is an evident tension between the proposals in the letter that speak of access, and the current Market Entry regulations that specifically identify the desirability of patient choice. The only reference to choice in the letter is in a paragraph that begins: "The Department will also consult on how best to drive new models of ordering prescriptions and collecting dispensed medicines." It says: "In future patients should be able to choose to order their prescriptions on line and have them delivered to their home if they wish, or to 'click and collect' if they prefer." We welcome this acknowledgment of patient choice, and are confident that pharmacies will deliver online services for their patients as online prescription ordering becomes a reality, but its use is very limited at present.

We believe the underlying objectives are incompatible with the Competition and Markets Authority's mandate to promote competition and its specific policies on competition in the provision of pharmacy services. This needs to be examined and debated. In discussions with the Department we have voiced our fears that patient choice will not be effectively protected in future arrangements. In recent years the transition to the Electronic Prescription Service from paper prescriptions has led to a massive upsurge in the direction of prescriptions by or with the support of GP practices (we emphasise that there is a minority of practices that have participated in this). In many such cases we have been able to identify a financial incentive for those involved. The NHS has not taken any effective action to protect patients' choice, and we fear this could be eroded further.

The Department's aim to 'drive' new models also needs to be examined. Is it right that it should seek to 'drive', rather than allow patient choice and pressure to determine what models they want? There are today hundreds of distance selling pharmacies, providing online services. Those that truly operate as DSPs should operate have a very limited market share, and we believe this reflects the service traditional bricks and mortar pharmacies offer, including providing the convenience and simplicity for patients of 'click and collect' or home delivery. Patients seem to believe that there is no benefit, and real disadvantage from the loss of a local relationship, so is it right that the Department should seek to drive this model rather than, as now, to ensure patients have a free choice? We believe it is not.

The key findings from the Healthwatch England briefing are:

"People spoke positively about pharmacies, saying they trust their pharmacist and think they could use them more to take pressure off hard-pressed family doctors.

In particular they referenced liking the private consultation rooms many pharmacists are now using, the home delivery of prescriptions and the flexible opening hours – a service which meets their needs as consumers."

The remote dispensary would not appear to meet these needs.

The Community Pharmacy Contractual Framework (CPCF) recognises the value of face to face services, in the requirements to support self-care, for signposting, public health campaigns and interventions, and for consultation rooms where pharmacies provide Advanced services.

Patients' views reflect their experience of community pharmacies, and it is clear that the highest users of pharmacy services place great emphasis on the importance of the personal relationship they have with their local community pharmacist and pharmacy team. These include not just those in the pharmacy, but also other members of the team, including, for the frailest in our communities, the delivery drivers who take medicines to housebound patients and in doing so often act as the eyes and ears for primary care. Developing and building on this so that patients understand and appreciate the expertise and skills of the pharmacist and the pharmacy team, would allow the NHS to ensure patients have the trust and confidence that is a pre-requisite to allowing pharmacies to take on work from GP settings.

In early 2015 we proposed changes to Market Entry rules that would support a reduction in pharmacy numbers in areas where there are what the letter terms 'clusters'. Those proposals were not taken forward and when we pressed, we were advised, in June 2015 that they were rejected as unnecessary. We are pleased that they have now been accepted. They will provide a framework that can support closely co-located pharmacies to merge their businesses. This is, in the negative environment that sadly has dogged this consultation, a reminder of how proper collaboration and mutual respect can produce good results.

6. THE NHS CAN IMPROVE CARE AND MAKE SAVINGS BY DEVELOPING PATIENT SERVICES FROM PHARMACIES

Throughout this response, we have emphasised our ambition to ensure that community pharmacies meet the needs of the NHS and of the patients and communities we are here to serve. We recognise the immense pressures facing the NHS and primary care in particular, and believe there is a great opportunity to further expand our services to offer this support in a way that builds on the current roles and relationships we have with our patients and local communities, and the skills of community pharmacists and their teams. This is what the proposals we have put forward[1] seek to do.

In this context, the distinction between community pharmacists and 'clinical' pharmacists, was repeatedly but falsely drawn by the Chief Pharmaceutical Officer in references to pharmacists working in GP practices. It was used throughout the consultation period, and by the implication that the community pharmacist had lesser or no clinical skills, contributed to the sense of a disparaging and prejudicial attitude towards community pharmacy being fostered by the Government.

We have said already that we never had an explanation for the sudden volte-face by NHS England in June 2015 on the commissioning of a national Minor Ailments Advisory Service (MAAS) from community pharmacies. We are aware that many local Minor Ailment Schemes are in operation, but these, because they are local and variable, cannot effect the change in behaviour and reduced demand on GP appointments of a standardised national service. We infer that there is a reluctance to commission and fund a scheme nationally, when at present any scheme commissioned is funded from local budgets. This is exasperating. We see an NHS buckling under the strain of manpower and financial pressures; we see GPs and their representative body calling for a national minor ailments service. And we see an NHS talking about the need for transformation, and demanding Sustainability and Transformation Plans, yet itself lacking the willpower to invest a relatively small sum to achieve a massive gain for primary care and patients.

A study many years ago, accepted by the Government and reflected in its earlier policy papers, identified 57 million GP consultations a year that could be removed by the commissioning of a national minor ailments service. Both Healthwatch England, representing patients, and the BMA, representing doctors, support such a service, and no wonder.

We put forward proposals for services helping people living with long term conditions that are supported by evidence of outcomes and that would offer real benefit and value for our communities and the NHS. They were developed to ensure that the GP service was not burdened by unnecessary demand and could be freed to deliver the care that really needed the skills of the GP. They did not find favour.

We have also offered to do more to promote healthy living and help prevent the burden to our health and care system from avoidable, lifestyle-related disease. We know the Government recognises the seriousness of the problem, but it does not seem to want to use the skills and opportunities offered by a sector ready, willing and able to help.

Although the letter spoke of the need for a clinically focussed community service, no proposals were put forward by the Department or NHS England, either in the letter or subsequently.

In addition to our service proposals we offered, as part of a package of proposals to save NHS costs, to ensure that patients who need urgent supplies of repeat medicines could access these directly from the community pharmacy, saving the costs of NHS 111 and out of hours GP services in most cases. The response to our practical and sensible offer, was a response suggesting a structure so burdened with bureaucratic and time-consuming requirements, with indefensible restrictions on patient access to the service and no additional funding, that it had to be rejected.

Our proposals to save the NHS hundreds of millions of pounds that are currently spent unnecessarily on costs of prescribed medicines demonstrate what can be done if sector skills are properly used. They have not been taken up.

[1] http://psnc.org.uk/wp-content/uploads/2016/02/PSNC-CPR-service-dev-proposals.pdf

PSNC PHARMACY the Heart of our Community

We continue to be willing and keen to work collaboratively with the Department and NHS England to achieve change in the services provided within the CPCF, to ensure patients and the NHS get the best value from the community pharmacy service. To this end, we have worked with Pharmacy Voice and the Royal Pharmaceutical Society, seeking to develop a *Community Pharmacy Forward View* which articulates our collective view on how we believe the community pharmacy network can best support the high performing, affordable health and care system envisaged in the NHS's Five Year Forward View.

We will be publishing this document shortly and we hope the Department and NHS England will consider its content and will engage with us in a discussion on how the proposed service developments contained within the document might be implemented to the benefit of patients and the NHS.

7. GOVERNMENT MUST BE HONEST, OPEN AND FAIR IN IMPLEMENTING A MAJOR CHANGE OF POLICY ON COMMUNITY PHARMACY

Community pharmacies, although their businesses are overwhelmingly NHS businesses, are privately owned, by individuals, small groups or large corporations. Common to all is that they bear the risks of owning the business. If the NHS changes its funding sum or method of distribution substantially, then the financial viability of a business is vulnerable to that change.

The policy to reduce pharmacy numbers was clear from the content of the letter and was explicit in early discussions with officials and ministers. We accept that the NHS can make changes designed to provide the pharmacies it wants, provided it does so with proper care and attention, but this must be combined with an expectation that it will treat fairly the owners who have invested in premises and providing services, if it decides it no longer wants them, or wants to change the rules so that they will become unviable.

We have sought, without success, to seek the rationale for the proposals put forward for an extremely complex database to rank pharmacies and underpin the proposed Pharmacy Access Scheme (PhAS). Despite repeated requests, we received a partial explanation only on May 13th, eleven days before the close of the consultation. Various sums of money have been put forward as being possibly needed to provide funds for the scheme, some of them large. In one discussion it was suggested that very large numbers of pharmacies could potentially be supported by (and therefore dependent on) the scheme. This level of dependence on top-up funding, which may be guaranteed for a three or at most a five-year period, would be indicative of a programme for a brutal cull of pharmacies, depriving communities of the resource they now enjoy.

The proposal for a complex and weighty PhAS is only comprehensible to us if there is indeed an unadmitted agenda to achieve a radical reduction in numbers. We need the Government to be forthcoming about its policies, so the general public can give proper consideration to the implications for local communities of the proposals.

The reluctance to explain the policies is, we believe, driven by a desire to avoid the opposition that they would provoke, and to forestall the argument that pharmacies which become unviable should be compensated. Its consequence is to avoid openness with the public and their elected representatives about plans that are very relevant to their health and wellbeing.

When the government decided to reduce numbers of Post Offices, it eventually accepted the need to compensate those businesses that would become unviable as a result. The same situation appears to exist here, and whether through a change of policy on 'clustering', on choice, or through changing funding systems so lower volume dispensing pharmacies' income is severely reduced, pharmacies affected should be offered the opportunity to close with a compensation sum that allows them to meet the costs of closure.

8. CONCLUSIONS

We have major, unaddressed concerns about the underlying aims and implications of proposals in the letter. We do not believe their impact has been properly evaluated or understood and certainly they have not been explained sufficiently to enable proper, mature and informed consideration of the proposals and their consequences.

The proposals contained in the letter constitute a major threat to the future availability to the public of an easily accessible source of informed health care, support and advice. This threat has not been made clear to the public or their representatives, and the policies underpinning the letter have not been based on analysis of the likely consequences or costs to the public as patients, members of our communities, or taxpayers.

The proposals do not take account of the informed views of patients or the public.

Proper, informed negotiations between the Government and PSNC have been made impossible by the lack of clarity, detail or analysis of the issues raised by the letter.

We are willing and keen to work collaboratively to achieve change, to ensure patients and the NHS get the best value from the community pharmacy service, to address problems and to work productively with the Department and NHS England. We hope to be able to do so in a more constructive way than has been possible through the last five months.

Community pharmacy, together with the pharmacists and support staff they employ, is a resource that is being neglected by policy makers. The solution to some of the capacity problems of NHS primary care services is staring the NHS in the face. Why is it turning away?

About PSNC

PSNC promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.