For the Attention of Keith Ridge
Chief Pharmaceutical Officer

Response to Community Pharmacy in 2016/17 and beyond and stakeholder briefing sessions document

East Sussex Local Pharmaceutical committee would like to respond to the documents as stated in the title and also the process used to consult with appropriate stakeholders.
We were very disappointed that LPCs were not seen as official consultees
We find that details are confusing with several deadlines leading us to believe that submissions should be received by 12th February 2016, but then consultation timings state the process will end on 24th March 2016. Government consultation guidelines are very clear that consultations should be clear and state timescales, which would normally be three months from the date of publication of a single consultation document. They should also be targeted to all relevant, specific stakeholders – this process should be transparent.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492132/20160111_Consultation_principles_final.pdf

In regard to the letter dated 17th December. We understand that community pharmacy must change, but this should be by a planned and co-ordinated approach. We appreciate that pharmacists should be utilising their clinical skills but we would wish to see this taken forward within the community pharmacy network as well as through pharmacists working within GP surgeries. We do not want to see changes compromising this network to disadvantage patients.

Messages expressed in your letter of the 17th December are mixed, with initially the DH being supportive of community pharmacy to enable the sector to relieve the pressure on GP surgeries and A&E departments, however this is later negated by the desire to close pharmacy outlets. Community pharmacy provides the most cost effective model of service delivery without direct employment and other overheads.

Cutting funding across the board is a blunt instrument which will force closures in those deprived and rural communities where they are most needed. Although the letter talks of a **pharmacy access fund** – the mechanism for delivering this fund sounds complex, lacks transparency and would build in bureaucracy and prove costly to administer.

Does the DH plan to dismantle the whole community pharmacy structure as it stands today and replace with a new model. The implied new model will remove the opportunity of a clinical pharmacist working in the community accessible when other NHS services are closed, which we believe would inherently build in costs for the NHS and the Government. The model at present has the clinical expertise and the locations to support the health of patients who are on stable medicines. It is essential that the propose **pharmacy integration fund** is ring-fenced for new models of care that fully integrate community pharmacy into the primary healthcare team.

Implementation of the 6% funding cut in October, with no clarity on its application will not give the community pharmacy network time to restructure their businesses to meet patients and the public's pharmaceutical needs. Furthermore the outcome from the consultation on the "hub and spoke" proposals will not be available before the October deadline.

We are concerned that there is no evidence that the changes proposed by the Department of Health will provide better care for the public and will produce cost efficiencies needed by the government. With fewer pharmacies other parts of the NHS will bear the brunt of increased public demand. Forcing pharmacies to close within a cluster will create a gap in local service provision as set out in the local pharmaceutical needs assessment and allow opportunistic applications for new pharmacies to open. Clusters would need to be defined in legislation.

Under the NHS Services 2006 (Part1 1(3)) all NHS services must be provided free of charge except where a charge has been expressly mandated by legislation. Hence under the present legislation no charge can be made for delivering NHS prescriptions. The hub and spoke model inherently builds in a "delivery" cost. This cost would need to be built into funding arrangements within legislation. Community pharmacy must not be expected to provide additional NHS services without additional funding.

In response to the questions posed within **"Community Pharmacy in 2016/17 and beyond – proposals."**

What are your views on the introduction of a Pharmacy Integration Fund?

Any funding for an Integration Fund would be welcomed by community pharmacy

What areas should the Pharmacy Integration Fund focus on?

This fund should be focussed on using community pharmacy and their pharmacists – who are all clinicians – to provide services for their patients working in tandem with their local GP practice, CCG and Social Care and closing involved in the Better Care and Transformation programmes in England

How else could we facilitate further integration for pharmacists and community pharmacy with other parts of the NHS?

Embedding community pharmacy in care pathways – medicines are integral to delivery of all healthcare. At the present time community pharmacists are always seen outside of care pathways, however they provide medicines to all patients across all conditions. Closer working with all healthcare partners facilitated by NHS England and through incentives for all parties.

To what extent do you believe the current system facilitates online delivery to door and click and collect pharmacy and prescription services?

At the present time patients find it difficult to order their prescriptions online from their GP surgery as they receive no feedback as to where their prescription sits in the process. If the prescription is received electronically then the pharmacy will dispense the prescription. Under the present legislation no charge can be made for delivering NHS prescriptions. This service is often provided free of charge by the supplying pharmacy.

What do you think are the barriers to greater take-up?

Patients want advice and support from their local pharmacy about taking their medicines. Many patients are elderly or disadvantaged in other ways and require and need the support of a local point of contact, which is their community pharmacy. Medicines are not just any commodity, but drugs which can cause harm if taken inappropriately.

How can we ensure patients are offered the choice of home delivery or collection of their prescriptions?

There are two ways this could be achieved.
Change the legislation to allow community pharmacy to charge for delivery.
Provide funding within the pharmacy contractual framework to provide this additional service

What are your views of the extent to which the current system promotes efficiency and innovation?

The present model ensures that the lowest cost option for drug procurement is used. Community Pharmacy receives allowances but the NHS is not directly responsible for employment or infrastructure costs. (making those allowances very cost effective). Innovation is held back by the lack of integration with other care providers.

Do you have any ideas or suggestions for efficiency and innovation in community pharmacy?

Innovation and efficiency is held back by the lack of an integrated IT system and read and write access to patients' medicines records. Innovation would be stimulated if General Practitioners and Community Pharmacy contracts worked in tandem and not in opposition. More defined local working of community pharmacy with Clinical Commissioning Groups would also stimulate innovation together with mandated incentives to all parties. Access to hospital discharge summaries would enhance patient care.

What are your views of encouraging longer prescription durations and what thoughts do you have of the means by which this could be done safely and well?

Over many years it has been established at a prescription for 28days supply is the optimum quantity. This aids compliance and helps to minimise waste. The introduction of electronic repeat dispensing, where it has been implemented supports patients to take their medicines and relieves pressure on GPs. To increase the duration of prescriptions would undermine the good work achieved to date. Increased duration of prescriptions may be of benefit to some patients, but this should be at the discretion of the prescribing clinician and not by a blanket directive.

What are your views on the principle of having a Pharmacy Access Scheme?

The principle of a Pharmacy Access Scheme is sound, however it must apply to both deprived and rural communities. To thrive a village needs a post office, a bus service and a pharmacy, remove one and the community dies.

What particular factors do you think we should take into account when designing the Pharmacy Access Scheme?

Any scheme needs to be administered using a national template, which must be simple, transparent and easy to access by community pharmacy contractors. It must be cost efficient to administer and be understood by all parties. Including the public.