Impacts of current funding, policy and economic environment on independent pharmacy in England

September 2020

Building a better working world

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Executive summary: this report in numbers

Community pharmacy is highly valued by patients

- 81% of patients hold a favourable view of pharmacists, higher than GP, optician and dentist groups according to a recent survey.
- During the COVID-19 lockdown, when other health providers were reducing face-to-face access, pharmacy stayed open; over this time 98% of pharmacies reported dealing with increased enquires about serious health conditions.

The NHS wants an expanded role for pharmacy, but financial pressures undermine this strategy

- Pharmacist consultations and other services can relieve pressure on GPs and planned care services, but 87% of pharmacies report they can not afford to take on the staff to provide more services.
- The NHS has encouraged longer opening hours for community pharmacy, but those with above average opening hours are almost 2x as likely to be in financial deficit.

Community pharmacy is a small proportion of healthcare cost despite its important role

- Community pharmacy funding in England is £2.6bn (2.3% of total NHS England spend), which has already been reduced by c. £200m since 2016.
- Community pharmacy's role is a contributary factor to UK medicines spend being 16% lower per capita than the OECD average.
- Community pharmacy manages the procurement and dispensing of £9.1bn of medicines in primary care

The community pharmacy network is unsustainable under the current financial framework

- We estimate that today, 28%-38% of the network is in financial deficit, with 52% of owners planning to sell their businesses.
- By 2024, we project this will rise to 64-85% under current funding arrangements.
- In our base case scenario, we project a network wide £497m deficit (19% of revenues)
- Persistent deficits of this scale will likely result in businesses having insufficient cash to continue trading and a contraction of the network
- No industry is likely to be sustainable with so many operators in deficit.

This report sets out these findings in greater detail, along with recommendations for the future of community pharmacy

Executive summary

Scope of this report

EY was commissioned by the NPA to undertake a body of work to:

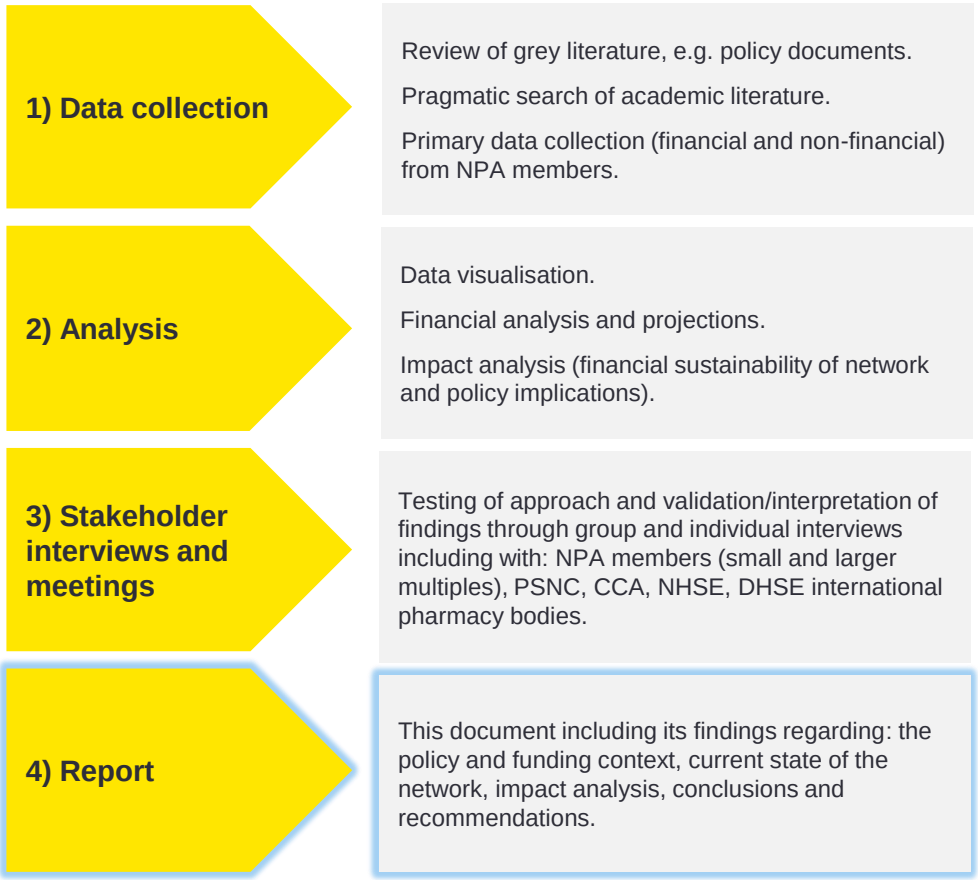
- Provide an overview of the historic context and current policy environment in which the community pharmacy network operates.
- Outline the current funding arrangements for community pharmacy under the 2019–24 Community Pharmacy Contractual Framework.
- Provide an overview of the activities and value delivered by community pharmacy.
- Provide an overview of the network, in particular the financial position of community pharmacies.
- Undertake projections of the future financial performance of the network based on historic trends and the current environment.
- Consider the impact of the projected financial performance of the network on its sustainability and the ability to deliver against policy objectives.
- Draw conclusions and make recommendations based on the analysis undertaken.

The scope of the work is restricted to the community pharmacy network in England.

Primary data collection was limited to NPA members, although analysis extends to the broader English network.

Approach

The diagram below sets out the key steps we undertook in developing this report.



Executive summary

Background – community pharmacies and their role

There are 11,539 community pharmacy premises in England, with around half of those being independently owned.

The NPA represents independent pharmacy, with many members being owners of a sole premise, while its largest member privately owns c. 300 premises.

The community pharmacy network represents a small proportion of healthcare cost despite its important role.

Community pharmacy funding in England is £2.6bn (2.3% of total NHS England spend), which has already been reduced by c. £200m since 2016, but community pharmacy manages the procurement and dispensing of £9.1bn of medicines in primary care (8.1% of total healthcare costs).

In this role Community Pharmacy contributes to the UK's cost control of medicines; the UK achieves a 16% lower spend on medicines than other OECD nations, with primary care prescribing spend falling in recent years (while hospital medicines spend has been increasing, leading to increases in overall medicine spending).

The historic NHS-funded role of community pharmacy in England has primarily focused on procurement of medicines and dispensing, but NHS England has a stated ambition to expand that role in order to support key priorities:

- Urgent care: by operating longer operating hours community pharmacies are able to support urgent care needs in their local communities.
- Primary care consultations: providing patient consultations otherwise provided by GPs to relieve demand pressure on primary care.
- Medicines management: community pharmacies are able to broaden their scope of responsibility in the management of medicines as they work more closely with local health services in primary care networks.
- Preventative health: through integration with local health services community pharmacies are positioned to play a broader role in supporting community health, including being commissioned locally to provide services such as smoking cessation.

Background – community pharmacy funding

NHS England accounts for c. 87% of revenues received by pharmacy services in the UK, with other income coming from additional services commissioned by local authorities and OTC sales. This purchasing scale provides NHSE with the ability to negotiate low prices on behalf of consumers, but presents a risk to the pharmacy services network to the extent that it results in NHSE having significant bargaining power with no independent financial regulator of these services ensuring network sustainability.

This type of monopolist power from a public market purchaser can be of benefit to society. However, it could also be harmful if it leads to a financially unsustainable market.

Historically the majority of funding for community pharmacy was based on the volume of medicines dispensed, in line with the core role of the network. This included an incentive mechanism for managing down the cost of medicines in the form of a retained margin on purchases (the difference between the cost of the medicines purchased and the funding received per item).

Community pharmacies receive remuneration from NHSE under the 2019-2024 community pharmacy contractual framework (CPCF). It includes:

- A fixed overall funding envelope for the network in nominal terms, meaning reducing funding in real terms (taking inflation into account).
- A cap on the margin the network can retain from medicines sales.
- Marginal cost based payments for nationally commissioned services (part of overall funding envelope).

The arrangements under the current CPCF differ from historical agreements which included fully loaded costings to determine remuneration. The implications of the CPCF are detailed in this report.

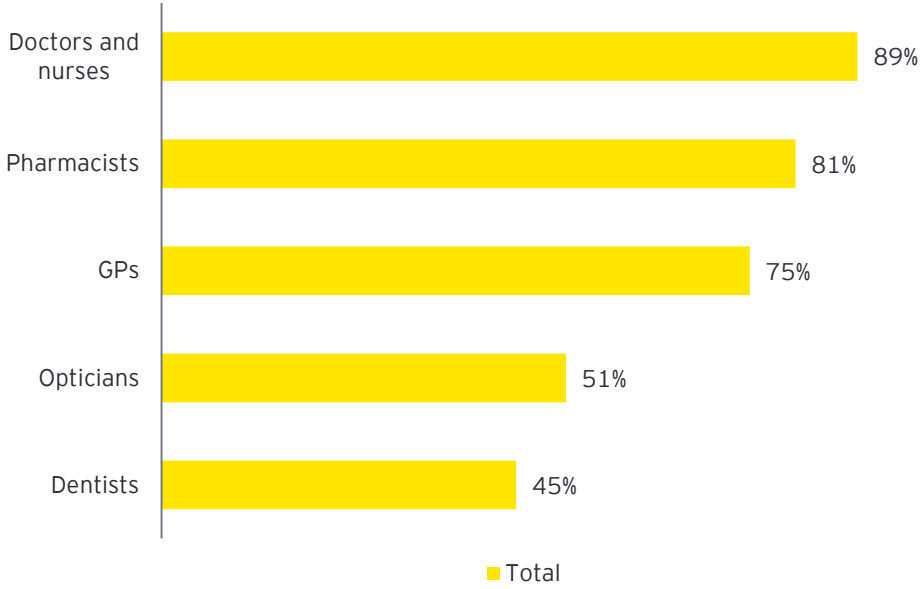
Executive summary

Value of community pharmacy

Trust is high for community pharmacy

In a recent survey commissioned by the NPA of 1,000 members of the UK general public, respondents were asked to indicate whether they have a favourable, neutral or unfavourable view of (hospital) doctors and nurses, pharmacists, GPs, opticians and dentists. Pharmacists were the second highest regarded group after doctors and nurses.

Figure 1 – NPA survey results, net favourability summary (HCPs)



Community pharmacy provides a crucial role in access to services and care

Pharmacy has provided services in the past proven to give good value and continues to play a crucial role in access to healthcare during COVID-19.

Through the COVID-19 lockdown, during which time access to face-to-face GP appointments were severely curtailed, community pharmacy played an important and expanded role in supporting patients.

The below figures highlight the experience of community pharmacists during COVID-19. It is unclear as to whether these changed demands might persist beyond the crisis or re-emerge if there is a second wave of COVID-19 cases.

Figure 2 – Increase in patients seeking advice for serious conditions

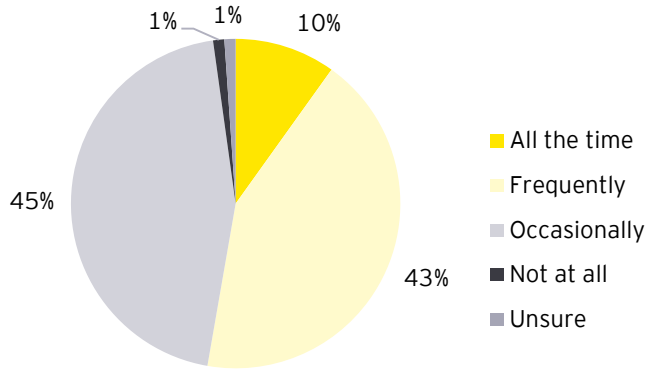
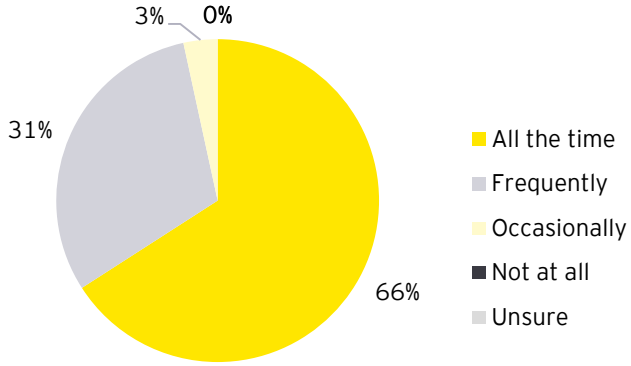


Figure 3 – Additional requests for home delivery services



Executive summary

Findings – current state of the network

A large proportion of the network is in deficit

Our sampling of the network suggested 28% of the respondents were in deficit in 2019. However, research conducted based on random sampling of pharmacy accounts from Companies House found 38% of the network to be in deficit.

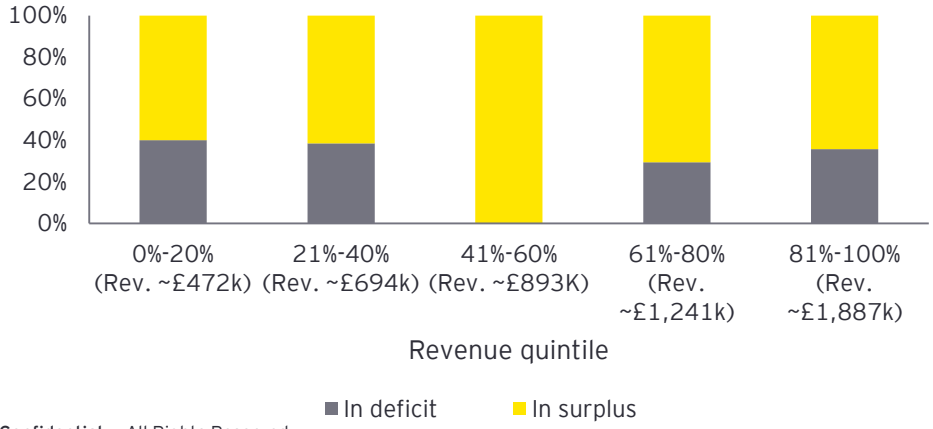
Pharmacies with longer opening hours are more likely to be in deficit

Of those sampled, premises in deficit reported to be open on average 57 hours a week. In contrast, those in surplus reported to be open on average 51 hours a week. This may be driven by staff costs and efforts to contain costs and may undermine the desired role of pharmacies supporting urgent care as financial pressures may force those with longer opening hours to close or restrict hours.

Bigger is not necessarily better

A similar proportion of pharmacies were in deficit comparing those in the bottom two revenue quintiles as those in the top two quintiles. Those in the middle quintile were least likely to be in deficit. This suggests that there may in reality exist stepped costs which might act as a barrier to expanding activity in surviving premises should there be a contraction in the network.

Figure 4 – Scale of revenue comparison (2018/19)



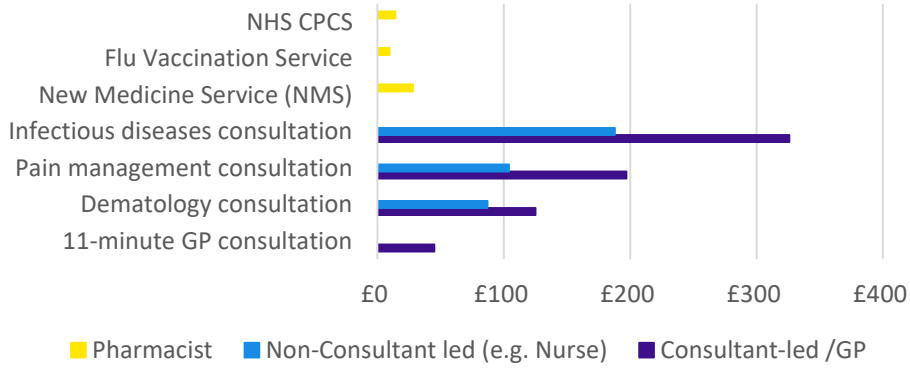
Providing services may not be financially viable

Respondents highlighted capacity constraints of current staff (71%) and inability to take on new staff due to financial pressures (87%) as key constraints preventing them from offering new services, while premises with an above average level of revenue from services were more likely to be in deficit.

NHS policy is to utilise pharmacy providing services to reduce pressure on secondary care and other primary care settings. However, pharmacies providing a greater proportion of these services (in terms of their revenue composition) are more likely to be in financial deficit, and when asked the barriers to providing more services the key issues raised were the affordability of staff to carry them out.

Benchmarking the fees paid for services carried out by pharmacies against analogous services in other settings reveals they are several times lower. The current low fees are likely to be a barrier to providing new or additional services.

Figure 5 – Remuneration for services comparison (2018/19)



Home delivery services are being retracted

Approximately 11% of respondents stopped providing home delivery services, previously provided for vulnerable patients. Of these, all respondents highlighted financial pressures and 91% suggested staff shortages as a reason for this.

Executive summary

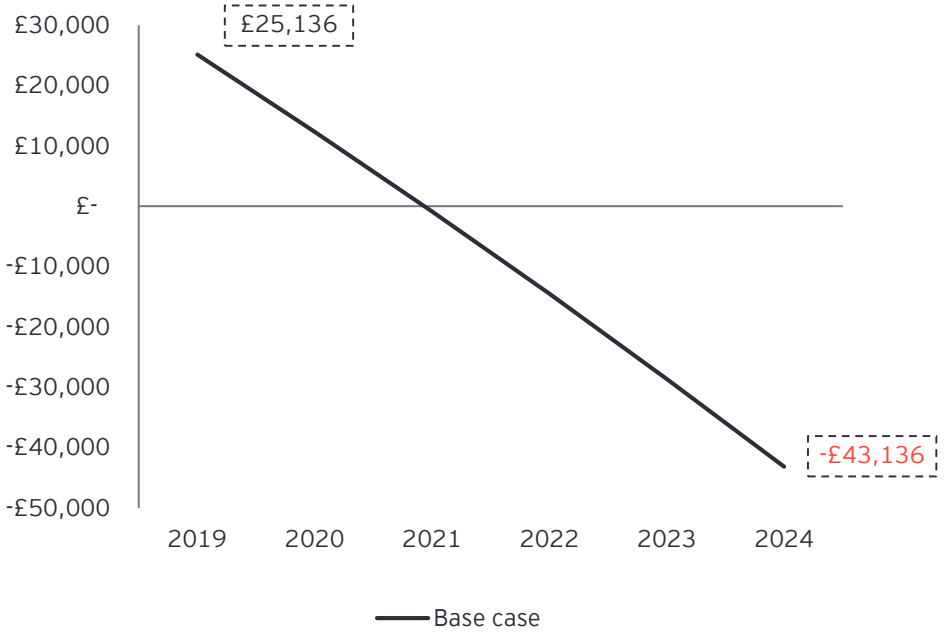
Findings – Projections

The average financial position of community pharmacy is worsening

We ran a number of scenarios for the future financial performance of community pharmacy, utilising different start points for the average 2019 deficit and projecting forwards using either historic trends or on an assumptions basis. In all cases we projected a steep decline. Our base case projection was the average pharmacy premise making a £43k deficit by 2024 (£497m for the network as a whole). This is an estimated average fall of £68,272 per pharmacy between 2019 and 2024.

Persistent financial deficits of this scale will likely result in businesses having insufficient cash to continue trading and a contraction of the network.

Figure 6 – Average surplus/deficit – base case



Community pharmacy is projected to move further into deficit

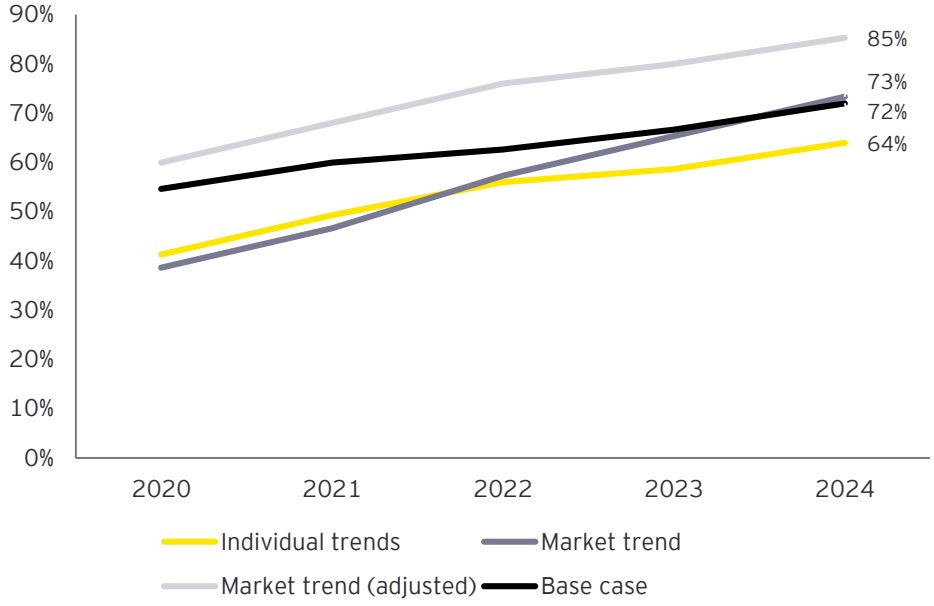
Looking at the whole network, by 2024, 64% to 85% of community pharmacy premises are projected to be in deficit.

The base case, which assumed revenues stabilise at 2019 levels and costs to increase at inflation rates dependent on the type of cost, suggested 72% of community pharmacies to be in deficit by 2024.

Such poor financial performance would place the financial sustainability of the network at risk, with significant implications for patients' ability to access local healthcare services and NHSE's ambition for community pharmacy.

These projections are made on data that predates the COVID-19 crisis. Based on our interviews it is likely the crisis will have further weakened the network although the long-term effects can not be ascertained as yet.

Figure 7 – projected proportion of the network in deficit*



Executive summary

Stakeholder interviews

We tested the approach and validation/interpretation of findings within the report with a set of stakeholders through a series of group and individual interviews, which resulted in a number of key observations categorised below.

01 COVID-19

During COVID-19, the nature of the core of the work dramatically changed. Other parts of the health services started to limit access. Pharmacy faced additional demand because it maintained access during the crisis. It is unclear as to whether these changed demands might persist beyond the crisis or re-emerge if there is a second wave of COVID-19 cases.

02 Services / Pharmaceutical services

Services provided by community pharmacies heavily rely on where you are located because they are commissioned by CCGs and local authorities. The process of tendering to provide these services can be onerous and future pricing can be unpredictable, making tendering for them unappealing. There have been instances of just 48 hours being given to produce a tender.

03 Costs

Costs have been contained through efforts like cutting operating hours and many proprietors are working additional unremunerated hours as they can no longer afford to pay for appropriate staffing. Fixed costs have increased (wages, rents and rates). For other parts of the economy these can potentially be passed on, however in pharmacy there is a flat 5 year remuneration contract.

04 Prescribing mix

Pharmacies – both multiples and small independents – have limited ability to influence prices of drugs or generic/branded mix. Even within large multiples similar premises may have different financial performance based on the prescribing patterns and medicines policies of local CCGs. This flaw in the funding mechanism creates winners and losers based on geographic location of a premise.

05 Safety

Robotics and the use of automated processes has been suggested as a potential solution to reducing dispensing errors within pharmacy. Whilst robotics will ensure that the picking of drugs is safer, additional clinical activities that sit alongside are out of the control of robotics. This includes advice on drug interactions and dose checking. As such, robotics will not affect error rates in these areas.

06 Efficiencies

NHSE is investigating a hub and spoke model to drive efficiencies amongst community pharmacies. Interviewees suggested these models would not be more efficient, and we were unable to identify published literature which evidenced potential efficiencies. There was an additional concern amongst interviewees that hub and spoke may involve handing over control of procurement to a potential competitor and community pharmacies may be hesitant to lose this control under the current remuneration mechanism.

Executive summary

Conclusions and recommendations

Based upon our findings we have developed the following conclusions and recommendations with regards to actions that could better support the community pharmacy network and how the network can in turn be enabled to better support NHS England's strategic priorities.

Conclusions	Recommendations
The COVID-19 crisis highlighted the importance of having capacity in the system to deal with unexpected demand, and with pharmacy playing a key role. This role and capacity will likely be required to meet the demands of future unforeseen issues such as a second wave of COVID-19 cases, or preparatory actions such as providing increased vaccinations ahead of winter.	NHS England should understand any contraction in the community pharmacy network limits the health system's overall ability to deal with crises and other spikes in demand such as winter pressures.
Overall funding appears insufficient to maintain the network at its current scale; with fixed funding and inflationary pressures driving c. 75% of the network into deficit by 2024 based on our analysis. Between 28% and 38% of the network is already estimated to be in deficit as of 2019. This may result in insufficient cash to continue trading and a contraction of the network, reducing access to care. Current funding arrangements and economic conditions risk constraining current healthcare service provision and may lead to increasing demand pressures on other healthcare providers. Primary care networks (PCNs), sustainability and transformation partnerships (STPs), integrated care systems (ICSs), general practice clinics and hospital emergency departments would be left to manage the consequences should a significant proportion of pharmacies exit the network.	NHS England should consider the current funding quantum insufficient to sustain the network. Without intervention from NHS England, only the financially strongest pharmacies will survive – limiting access to essential health services in unprofitable areas. Policy makers should put in place public interest focused safeguards against the English community pharmacy network collapsing as an unintended consequence of short-term cost saving.
Increasing the volume and accessibility of services community pharmacy provides are key aims of NHS England in better supporting other parts of the planned and urgent care systems, but low prices and mismatched incentives are a barrier to investing in these.	NHS England should set prices and funding at a level that supports stated strategic priorities and puts the right incentives in the system. For example, prices based on a fully loaded cost with reasonable certainty over future funding. This would help to incentivise investment in capacity and support pharmacies to sustainably offer services.
The process of commissioning local services is seen by the network as onerous and a barrier to providing services, while pricing methodologies for nationally commissioned services are inconsistent with those utilised in other parts of the health system and other regulated industries. The absence of independent financial regulation places the performance and sustainability of the network at risk, especially given NHS England's near-monopsonist status.	Department of Health and Social Care and NHS England should consider either adopting the principles the government has set out regarding good economic regulation with regards to the community pharmacy network, or establish an independent financial regulator for the system. Good (independent) financial regulation that mitigates the risks of a monopsonistic purchaser could be an important enabler of financial and clinical sustainability for the NHS.

2 Scope and Method

Scope

EY was commissioned by the National Pharmacy Association (NPA) to provide analysis on current funding arrangements, policy and economic factors that are impacting community pharmacy in England.

Scope of analysis

EY was commissioned by the NPA to undertake a body of work to:

- Provide an overview of the historic context and current policy environment in which the community pharmacy network operates.
- Outline the current funding arrangements for community pharmacy under the 2019–24 Community Pharmacy Contractual Framework.
- Provide an overview of the activities and value delivered by community pharmacy.
- Provide an overview of the network, in particular the financial position of community pharmacies.
- Undertake projections of the future financial performance of the network based on historic trends and the current environment.
- Consider the impact of the projected financial performance of the network on its sustainability and the ability to deliver against policy objectives.
- Draw conclusions and make recommendations based on the analysis undertaken.

Activities

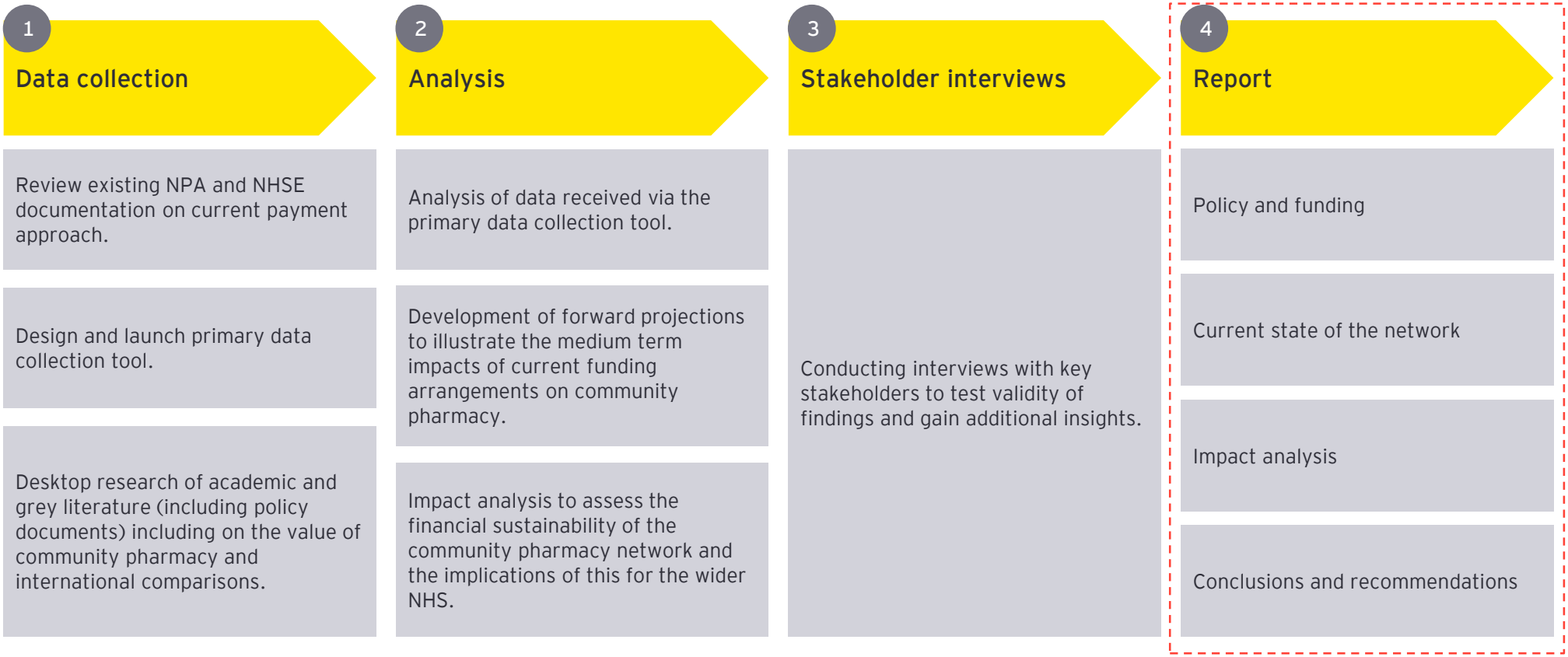
- Review and analysis of academic and grey literature.
- Design and launch data collection tool – primary financial and non-financial data collection including historical data to allow the analysis of trends.
- Analysis of the data provided by NPA members and development of forward projections on medium-term impact of current funding arrangements.
- Interviews with key stakeholders to test validity of findings and gain additional insights.
- Critical analysis of the data collected and financial projections.

Method – Overview

The method for completing this assignment is set out in the diagram below, with the yellow chevrons detailing the steps for each of the activities and the grey squares summarising each of their respective components.

It should be noted that while these are presented conceptually as successive steps, the tight timescales of the project and the complex nature of the subject matter meant in practice a number of the activities ran concurrently and in some instances the emergence of new findings or data necessitated cycling back to previous steps.

The remainder of the methods and scope section outlines the key themes and detailed approach for the primary data collection tool, literature review and stakeholder interviews.



Method – NPA primary data collection tool

Primary data collection tool

A primary data collection tool was designed and sent to NPA members to build an understanding of how the current pharmacy funding model is impacting community pharmacies across England.

Key research questions

Key research questions the tool was intended to answer included:

1. What is the current service landscape for community pharmacies across England?
2. How has financial performance changed over time, and what is the relationship to current funding arrangements?
3. Which types of community pharmacies are facing the highest financial risk?
4. What has been the experience of community pharmacies during COVID-19?

Types of data collected

The vast majority of data collected was in relation to individual premises. This was to allow a detailed segmented analysis on how current funding arrangements are impacting different parts of the network including by locality, staffing mix, prescription volume/mix and types of services offered, which would be obscured at a group level for multiples.

Types of community pharmacy ownership

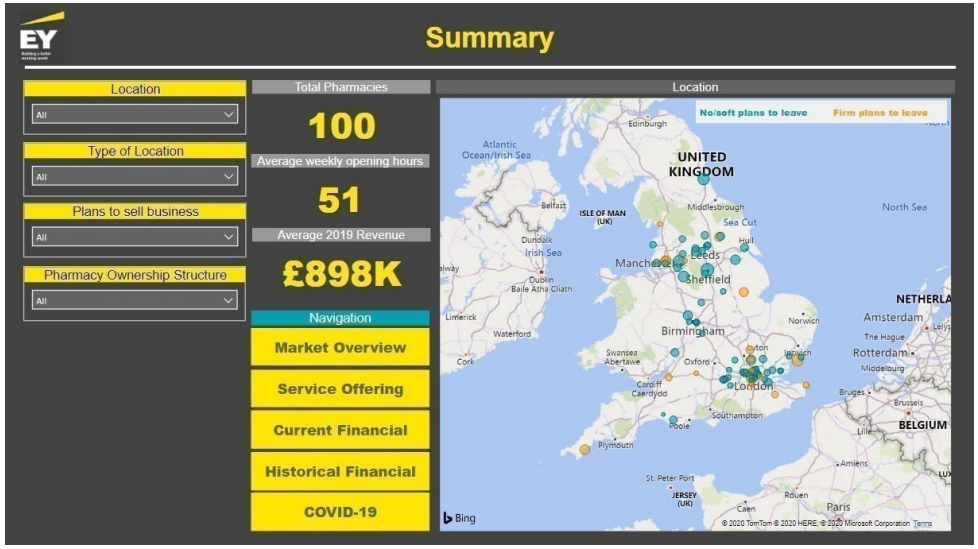
Analysis was segmented by different types of ownership structures. These include large multiples (owning 100 or more premises), small multiples (owning between 6 and 99 premises), and independents (owning between 1 and 5 premises).

Analysis of data

Data was cleaned and aggregated into a complete dataset of all responses and uploaded into data analytics platform PowerBI for further analysis.

The platform allowed for financial and service data to be visualised to inform stakeholder interviews.

Further analysis of the data was undertaken in excel.



Method – Literature review

Literature review

Desktop research of academic and grey literature (including policy documents) was completed on the value of community pharmacy including international examples. The review was based on an adapted version of the PICOS framework to determine the suitability of research studies based on the population, intervention, comparison, outcome and setting.

Key research questions

The literature review was undertaken following 8 key steps:

1. Define research questions.
2. Define relevant search terms.
3. Define inclusion criteria.
4. Select 15 abstracts from Google Scholar for review per research question for initial review.
5. Select relevant studies to include for detailed review (N=91).
6. Search specific alternative literature sources where primary search source (e.g., Google Scholar) has not yielded results.
7. Supplement with additional papers known to and provided directly by NPA.
8. Draft detailed summary of selected relevant studies to include in final report (N=48).

The research questions we utilised to define our search terms are detailed in the opposite panel. It should be noted that these were inputs to inform our searches, and we did not identify data relevant for inclusion in this report for some of the questions.

Research questions:

1. What is the health impact of community pharmacies?
2. What is the economic impact of community pharmacies?
3. What is the impact of community pharmacies on the high street?
4. What is the impact of community pharmacies on wider health system costs?
5. What is the wider social value created by community pharmacies?
6. What additional scope of services could UK community pharmacies provide?

Inclusion criteria

- Limit research papers to 2015 – present.
- Limit research papers to the context of community pharmacies.
- Limit research papers to England (except for international comparison research).

Other search sources:

- NPA
- PubMed
- ResearchGate
- Kings Fund
- OECD

Method – Stakeholder interviews

Stakeholder interviews

Interviews were undertaken with key personnel in the NPA, NPA members with a variety of ownership, and other relevant bodies including the international arena. The interviews were used to build upon insights from other workstreams and develop a broader picture of the business challenges and opportunities for community pharmacies.

Approach

Stakeholder interviews were undertaken via the following key steps:

1. Key stakeholders identified by the NPA.
2. Draft high level template discussion points.
3. Review of key stakeholder list and tailor high level template to individual stakeholders.
4. Undertake interviews.
5. Write up results.

High level interview discussion points

High level interview discussion points sought to address the following:

- Impact of the current funding model on community pharmacy.
- Impact of the current funding model on healthcare in England.
- Wider social impact of community pharmacies.

Key stakeholders groups identified

- NPA members – including owners of small and larger multiples
- Pharmaceutical Services Negotiating Committee regional and leadership teams
- National and international community pharmacy representative groups
- NHS England and the Department of Health and Social Care pharmacy teams
- National public health bodies and professional organisations
- National patient advocacy charitable organisations

Limitations and mitigations

	Limitation	Mitigation
1	Depth of analysis limited by the volume of data collected from 105 community pharmacy premises from our primary data collection exercise. Further, financial data collected does not include pension provision for owner, full costs of capital, salary drawn in the form of dividends or taxes paid by a business.	To supplement our primary data collection, we utilised research previously undertaken for the General Pharmaceutical Council (GPhC). This study involved a review of the whole community pharmacy network for Great Britain. It utilised a random sampling approach and publicly available financial data from Companies House, including audited financial accounts. An additional dataset was collected to demonstrate dividends in lieu of a salary.[43]
2	Financial data collected in the public domain does not include the impact of COVID-19.	It is likely the underlying financial position of community pharmacies have worsened in the face of COVID-19. As financial accounts have not yet been prepared for FY2020, we have qualitatively asked about the impact of COVID-19 during stakeholder interviews.
3	Analysis is limited to the community pharmacy network in England.	The focus of this report is community pharmacy in England. However evidence was collected from other jurisdictions during the literature review and during stakeholder interviews.
4	Primary data collection tool distributed to all NPA members but not CCA members, possibly limited extrapolation of findings to the whole network.	As per item 1, we supplemented the primary data collection exercise with publicly available data which included data for CCA members.
5	The literature review is limited to documents published electronically in the English language supplemented by literature provided by the NPA.	All evidence collected through literature was then further tested with stakeholders during interviews to ensure accuracy of interpretation.

The financial projections included in this report have been produced for the sole purpose of illustrating the current state of the community pharmacy network in order to inform recommendations made in this report. No reliance should be placed on these projections for any other purpose or by any third parties.

3 Background: Policy and funding

The English health system and Long Term Plan – Community pharmacy accounts for less than 3% of the total NHS England budget

The English health system

Funding flows from HM Treasury through to the Department of Health and Social Care, which is split across several health organisations who commission healthcare services from a range of providers.

Department of Health and Social Care (DHSC) – £125.3bn 2018/19

- In England, DHSC is responsible for allocating budgets from Treasury and setting policies associated with healthcare.
- A proportion of the DHSC's budget (£125.3bn 2018/19) is allocated to non-departmental agencies and bodies, such as Health Education England.

NHS England (NHSE) – £112.7bn 2018/19

- NHSE is responsible for commissioning primary care services, which includes community pharmacy.
- Community pharmacies receive £2.592bn per annum from NHSE under the current Community Pharmacy Contractual Framework (CPCF) to deliver a range of services. This accounts for less than 3% of NHSE total spend (see Figure 8).
- Drug spend (primary prescribing) in 2018/19 was estimated at £ 9.1bn, representing 8.1% of total NHSE spend. This figure is based on the medicines list prices rather than prices paid by NHSE and should be understood as an estimated spend.

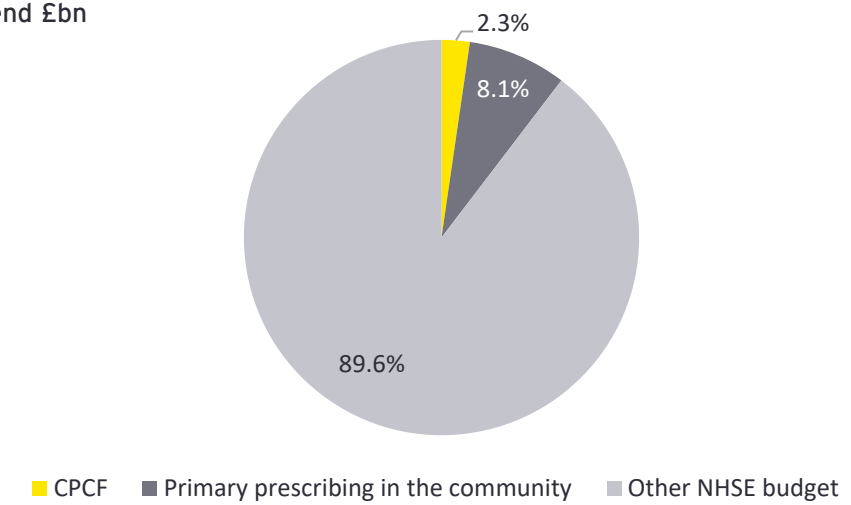
Clinical commissioning groups (CCGs) – £84.5bn 2018/19

- The majority of NHSE funding is passed on to CCGs (£84.5bn 2018/19), who procure services from providers such as hospitals, GPs and other community-based providers.

Other sources of funding healthcare services

- Local authorities also commission community pharmacies to provide additional healthcare services (e.g., smoking cessation).
- Other income to community pharmacy is provided by individuals who pay for private healthcare.
- These other sources of funding are however relatively small, as covered later in this document.

Figure 8 – 2018/19 NHSE community pharmacy spend as % of total NHS spend £bn

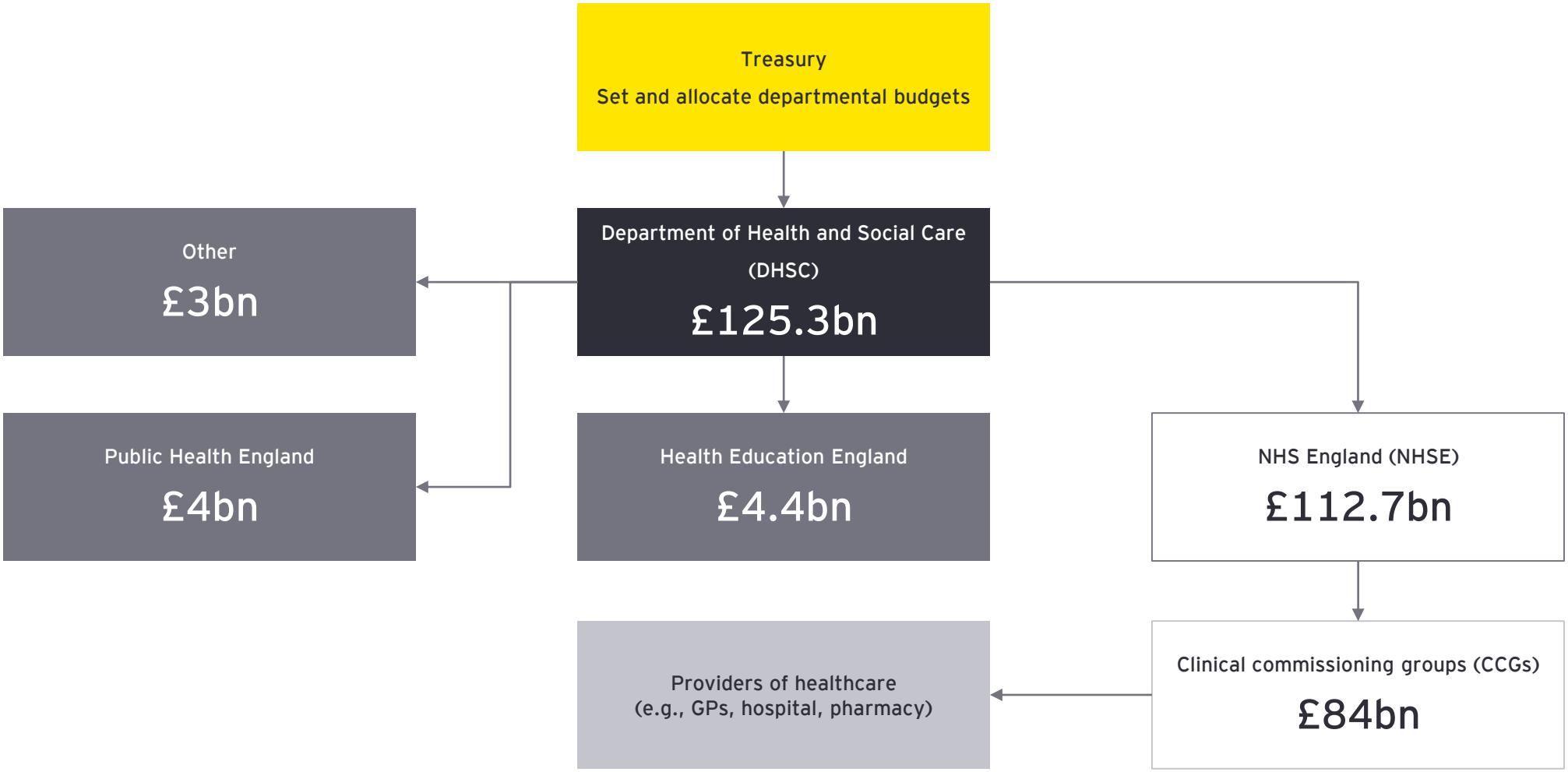


Key findings

Current levels of community pharmacy funding under the CPCF represent a small proportion of NHSE total spend and are substantially lower than the value of the medicines which they procure, dispense and help control the costs of.

The English health system and Long Term Plan – Community pharmacy accounts for less than 3% of the total NHS England budget (cont'd)

Figure 9 – 2018/19 England healthcare system funding flow[1]



The English health system and Long Term Plan — The NHS Long Term Plan will have far reaching impacts on the whole healthcare system

The **NHS England Long-Term plan** published 7 January 2019 sets out key long term priorities of the NHS. These include improving services across primary and community based settings, improving resource allocation and addressing workforce challenges in addition to system priorities to integrate care and reduce inequalities.[2,3] Further detail on the importance to community pharmacy is provided on subsequent slides.

Priority area	Key priorities	Key ambitions
Improving services	Clinical priorities	► Improve detection, care and early diagnosis for a number of clinical areas (e.g., cancer, CVD, mental health, stroke, diabetes) and a strong focus on maternity, children and young people's health.
	Primary and community services	► Develop 'fully integrated community-based healthcare' alongside primary care networks (PCNs), which will involve developing multidisciplinary teams (e.g., GPs, pharmacists, district nurses) working across primary care and hospital sites.
	Mental health and learning disabilities	► Improve service design, such as reduced waiting time standards for emergency mental health services ► By 2023/24, inpatient provision for people with learning difficulties or autism will have reduced to less than half of the 2015 level.
	Acute services	► GP-led urgent treatment centres (UTCs) will be rolled out nationally by 2020 to create greater consistency with urgent care outside hospitals. ► Reduce up to a third of face-to-face consultations to improve convenience for patients, free up staff time and save £1.1bn a year assuming that appointments continue growing at the current rate.
Resources	Finance and productivity	► Balance the provider market by 2020/21 and for all NHS organisations to balance by 2023/24. ► NHS to deliver savings from administrative costs of more than £700m by 2023/24.
	Workforce	► Shift the balance from specialised to generalist roles in primary care teams (e.g., clinical pharmacists and physiotherapists) to meet the needs of patients with multiple long-term conditions.
	Digital	► By 2020/21, people will be able to use the NHS app to access their care plan and communications from health professionals and all secondary care providers to become 'fully digitised' by 2024.
	Leadership and support for staff	► Increased support for current staff, including increasing investment in CPD (depending on the Spending Review), taking steps to promote flexibility and career development.
System priorities	Role of patients and carers	► Training staff to be able to have conversations that help people make the decisions that are right for them (e.g., diabetes prevention and management).
	Integrated care and population health	► Shift towards integrated care and place-based systems through ICSs, which will cover all areas of England by April 2021 — and will increasingly focus on population health.
	Prevention and health inequalities	► Greater collaboration between NHS and local authorities to address key disease areas (e.g., smoking, high-blood pressure, obesity, alcohol and drug use). ► By 2023/24, NHS-funded tobacco treatment services offered to all smokers admitted to hospital.

Source: Adapted from King's Fund, NHS Long Term Plan explained

The English health system and Long Term Plan – Community pharmacies are being asked to deliver more with similar funding

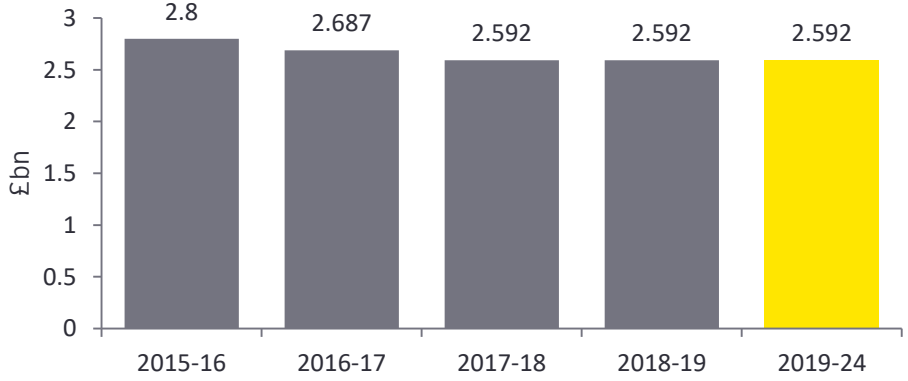
NHS Long-Term Plan in relation to community pharmacies

Under the latest CPCF the role of community pharmacy 'contractors' is set to expand in areas of urgent care, medicines optimisation and ill health prevention to better utilise the skills and reach of these professionals.

Trends in funding settlement

The NHSE funding settlement for community pharmacy has declined gradually from 2015–16 at £2.8bn and stagnated in nominal terms since 2017–18.[4,5] This trend is set to continue under the 2019–24 community pharmacy contractual framework (CPCF), which has been set to support the NHS Long Term Plan[6]. In real terms (factoring inflation) this will mean decreasing funding. There are expectations from Government that the level of required funding for dispensing activities will reduce over the course of the settlement as technological advancements are made and transformation is enabled. The CPCF outlines that any surplus funding will be reinvested to fund further service provision by community pharmacy.

Figure 10 – Community pharmacy funding settlement*



* Funding is held constant at £2.592bn in nominal terms annually in years 2019-24. Due to inflationary pressures, this means in real terms funding is decreasing each year.

Types of services under the 2019–24 CPCF.

Community pharmacies are commissioned to deliver a range of services under the CPCF[7]. These are classified as the following:

- Essential services are those that all community pharmacies must deliver to receive funding (e.g., repeat dispensing of chronic medication prescriptions).
- Advanced services are those that can be delivered by community pharmacies (e.g., Medicine Use Reviews) once accreditation requirements have been met.

Locally commissioned services

Locally commissioned services 'enhanced services' are not covered by CPCF, but funded through local authorities, CCGs and local NHS teams and include minor ailments prescribing and involvement in smoking cessation programs.

The role of community pharmacy is evolving

Community pharmacies are beginning to deliver a wider range of health and prevention services including screening and vaccination programmes.

These changes are covered in greater detail in the following pages.

The English health system and Long Term Plan – Community pharmacies will need to deliver more with similar funding (cont'd)

NHS Long-Term Plan in relation to community pharmacies

Under the latest CPCF the role of community pharmacy 'contractors' is set to expand in areas of urgent care, medicines optimisation and prevention to better utilise the skills and reach of these professionals.

Different types of payment under 2019–24 CPCF

Under the CPCF, community pharmacies have access to forms of transitional payments to support costs associated with delivering a more service-based role. For instance, during 2019/20 and 2020/21, a monthly transitional payment (annual sum of £69m and £223m respectively), which will be linked to prescription volumes, will be made available to contractors to support preparations for service model change (e.g., local PCNs), patient access to medicines (Serious Shortage Protocols) and implementing the Falsified Medicines Directive (FMD).

Additional payments to community pharmacies

In addition to transitional payments, a Pharmacy Integration Fund (PhIF) was established in October 2016 to support the rollout of clinical pharmacy in a wider range of primary care settings[5]. The PhIF currently supports a range of initiatives including pharmacists in integrated urgent care. DHSC stated that £100m would be made available in 2020/21 to meet its £300m target by 2021/22, but there is less clarity on how this is accessed at an individual pharmacy level. The funding has been designed to support both community pharmacy and GP-based pharmacy, however it's unclear how the funding has been delivered.

Changes with the Quality Payments Scheme

Under the 2019–24 CPCF, the Quality Payments Scheme (QPS – established to reward pharmacies with additional funding for meeting certain quality criteria) has been superseded by the Pharmacy Quality Scheme. This places greater emphasis on integration (e.g., PCN's) and clinical services in addition to pharmacists' traditional dispensing role.[6]

Figure 11 – Changes with the Quality Payments Scheme

	2016–18 CPCF	2019–24 CPCF
Payment scheme	Quality Payment Scheme	Pharmacy Quality Scheme
Amount	£75m per annum	£75m per annum
Domains	▸ Clinical effectiveness ▸ Patient safety ▸ Patient experience ▸ Public health ▸ Digital ▸ Workforce	▸ Clinical effectiveness ▸ Risk management and patient safety ▸ Public health ▸ Digital ▸ Workforce ▸ Integration in PCNs
Key changes	▸ Preparation for integrating with PCNs. ▸ Greater emphasis on completion of CPPE training (e.g., 80% of all pharmacy professionals within a premise). ▸ Requirements to take on further training (e.g., suicide prevention). ▸ The Healthy Living Framework (HLP) to become an essential component of the CPCF. ▸ All patient-facing staff required to be dementia friends (previously 80%). ▸ Greater focus on shift to digital (e.g., NHSmail, improved community pharmacy profiles for NHS 111 Directory of Services).	

Key implications for 2019–24 CPCF

Our review of the Pharmacy Quality Scheme suggests that whilst funding levels will remain unchanged in nominal terms, it will require a greater level of investment from community pharmacies to train their workforce and deliver additional services.

The English health system and Long Term Plan – NHS policy directs towards stronger partnerships and integrated care systems

The English health system

The English health system is gradually pivoting to new integrated care models which will significantly change the landscape of health provision impacting all services.

Provider and Commissioner partnerships

Partnerships are evolving between healthcare providers, commissioners, local authorities and other local partners to better meet the health needs of local populations.

Primary care networks (PCNs)

- Collaboration of multidisciplinary teams including general practices, community pharmacies and other local/community partners to deliver coordinated, holistic and local out-of-hospital care (typically covering 30k–50k people).[2]
- Suitably qualified community pharmacists and pharmacy technicians may be requested to join a PCN pharmacy team.
- There is an intention for PCN pharmacists to be better utilised in delivering care through these networks, e.g., through structured medication reviews, antimicrobial stewardship and supporting care homes.
- PCNs are at varying levels of development.

Sustainability and transformation partnerships (STPs) and Integrated care systems (ICSs)

- Since 2016, the NHS has formed partnerships with local authorities in 44 areas across England to focus on delivering co-ordinated services.[8]
- NHSE Long Term Plan set out plans for STPs to mature into ICSs by April 2021.
- These will support the integration of population-based models of care across primary, secondary and community settings.

ICSs' priorities include:

- Expected shift in commissioning with acute providers expected to take on enhanced roles for some functions typically carried out by CCGs.[9]
- Addressing challenges with capacity constraints in current and future workforce, such as system-wide working.
- Focus on improving the integration of primary and community care services through PCNs.
- The ICS model places emphasis on collaboration rather than competition, which could enable greater integration with the right legislation in place.

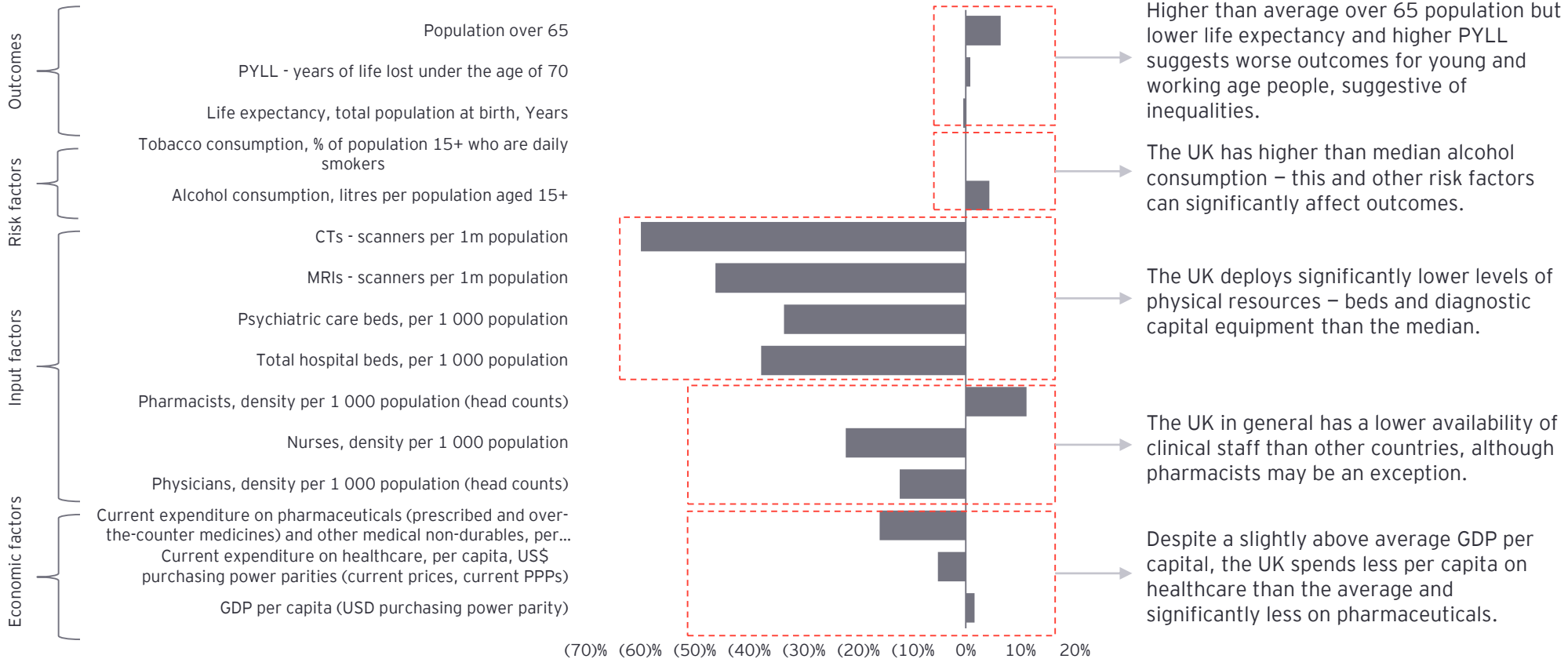
Implications for community pharmacies

- **More diverse pharmacy services:** Increased commissioning by acute providers could result in a more diverse set of pharmacy services which are integrated across primary and secondary care.
- **System-wide working:** ICSs and PCNs will place greater emphasis on system-wide working meaning a shift in the role of pharmacists (e.g., operating across various care settings and in multi-disciplinary teams).
- **Increasing role of the community pharmacist:** Potential for independents and smaller chains to play a role in serving local populations through PCNs.

International benchmarks – Pharmacy workforce may be in a stronger position than other professions to expand services

Comparing the UK to OECD counterparts, the UK deploys significantly lower levels of physical resources and in general has lower availability of clinical staff. However, the UK has a higher proportion of pharmacists (but a lower proportion of pharmacies). This potentially presents the opportunity to expand the current role of pharmacists as set out in the NHS Long Term Plan.

Figure 12 – Health system measures: UK vs median as % of median



Source: EY Analysis, OECD data 2018 or next latest available (a pre-COVID-19 view)

Value of community pharmacy in England – Significant and growing body of evidence on the benefits of pharmacy services

Value of community pharmacy in England

Pharmacy's position to expand services is further supported by evidence that community pharmacies are contributors to the sustainability of the NHS. Community pharmacies provide value through essential and enhanced services (those they must provide, and those funded optionally through local authorities), urgent and preventative care. A review of literature has highlighted the value that is being delivered through such services.

A review of the existing literature suggests that pharmacies can make significant contributions to health services beyond the core medicine supply role.

Community pharmacy contributing to the sustainability of healthcare systems

- Previous studies suggest that community pharmacies are effectively managing minor ailments, which has reduced demand pressures from relatively high-cost settings (e.g., GPs and acute care).[10, 11, 12, 13]
- In England, 57 million General Practice appointments each year are spent on seeing patients with minor conditions that could be self-treated; at an estimated £2bn annual cost to the NHS suggesting that there is scope to do more.[14]
- Reduced rates of admission and fewer days spent in acute care were reported when patients transferring from inpatient to outpatient settings via electronic referral received follow-up consultations from community pharmacies.[15]

Community pharmacies supporting urgent care

- Results from an observational study reviewing emergency hormonal contraception (EHC) observed significantly lower average waiting times for community pharmacies when compared to family planning clinics.[16] However there could be further scope to enhance the role of pharmacists, such as signposting follow-up consultations.[17]

Community pharmacies supporting preventative care

- In one study of oral health, community pharmacies improved knowledge of 72 percent of survey respondents, whilst 66 percent reported they would positively change their behaviour. Patients received a five-minute consultation, whilst waiting for their prescription and findings highlighted that whilst most patients were poor dental attenders, they were open to a pharmacy-based oral health intervention.[18]
- Community pharmacies delivered an educational programme for patients with mild to moderate symptoms of psoriasis, which improved knowledge, reduced disease severity and had a positive impact on patient's quality of life[19]. There is further potential to increase awareness of the role community pharmacies can play in supporting self-management of diseases.[20]

As pharmacy continues to expand the variety of services, it will be an increasingly vital part of primary care health provision. Provision of new and expanded services will be expedited through integrated care, primary care networks as well as the Pharmacy Quality Scheme.

Value of community pharmacy in England – Opportunity to continue to build the profile of pharmacy and innovate

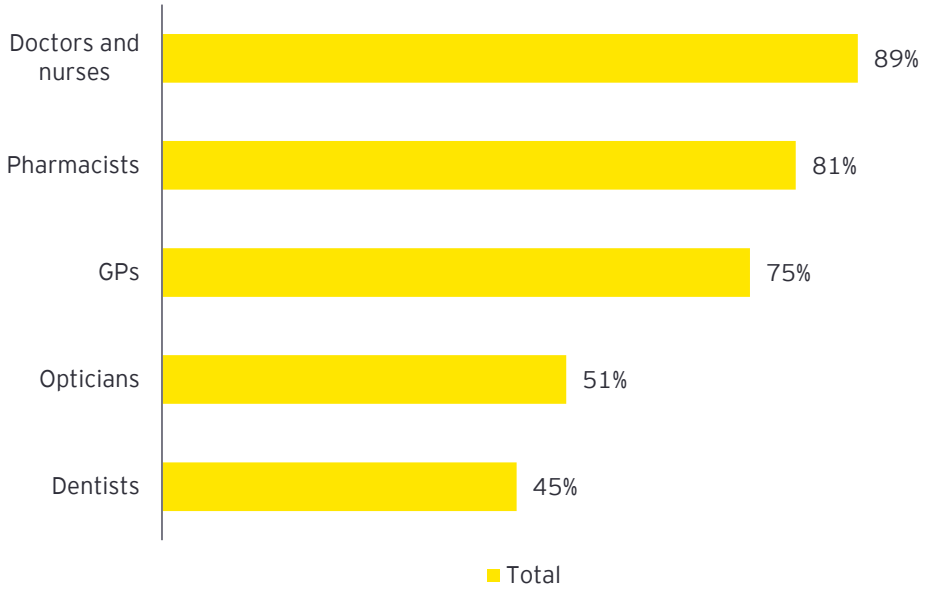
International examples highlight further value English community pharmacies could provide

In Scotland, Canada and Switzerland, community pharmacists have shown their ability to improve patient outcomes.

- **In Scotland**, there was a substantial increase in the proportion of prescriptions dispensed to treat Urinary Tract Infections (UTIs) after the national implementation of 'Pharmacy First' in 2017 (12% increase between 2017 and 2019). Dispensing was found to be appropriate and meeting clinical needs. Findings highlighted that community pharmacists could play a central role in the diagnosis and treatment of uncomplicated UTIs and potentially other common conditions.[21]
- **In Alberta**, Canada, community pharmacists managed patients at risk of hypertension and delivered an additional 0.4 quality-adjusted life-years and $6,364 cost savings over 30 years per patient.[22] The medication programmes range from assessments, setting clear health goals, monitoring and managing medications and promoting greater self-management of conditions.[23]
- **In Switzerland**, a triage approach to treating patients led by community pharmacists resulted in 84% of patients treated solely by pharmacists reporting complete relief or symptom reduction.[24] Research suggested the efficiency and sustainability of the service was underpinned by being fully integrated into the healthcare system.[24]

In a recent survey commissioned by the NPA of 1,000 members of the UK general public, respondents were asked to indicate whether they have a favourable, neutral or unfavourable view of (hospital) doctors and nurses, pharmacists, GPs, opticians and dentists. Pharmacists were the second highest regarded group after doctors and nurses.

Figure 13 – NPA survey results, net favourability summary (HCPs)



Source: NPA patient survey. 2020

As a familiar and widely used part of the healthcare system, pharmacy is nationally positioned to expand its clinical role. There are new services being planned and additional opportunities to develop looking at innovative practices and evidence from around the world.

Value of community pharmacy in England – Pharmacies played a significant role supporting patients during the COVID-19 crisis

Role in crisis management

Through the COVID-19 lockdown, during which other health services, including access to face-to-face GP appointments were severely curtailed, community pharmacy played an important and expanded role in supporting patients.

Role during COVID-19

- The COVID-19 crisis saw unprecedented demand on the NHS and a shift in population behaviour in terms of access to care.
- There was a sharp decline in expected attendances in Emergency Departments and cessation of face-to-face in GP appointments indicating unmet need.
- Community pharmacies continued to provide services and care for patients who were unable to access care elsewhere.
- In the data collection exercise of community pharmacies across England, ~70% of respondents said they had experienced an increase in patients seeking advice for minor ailments either frequently or all the time within the first three months of lockdown.
- Most of the pharmacies also stated an increase in presentations for advice for more serious conditions.
- This has further demonstrated the value of community pharmacies to local populations which have coped well despite increasing pressure on securing resources (e.g., for home delivery services) and financial pressures e.g., generic medicines cost increase of 22.8% according to our survey of pharmacies in England.

Figure 14 – Increase in patients seeking advice for serious conditions

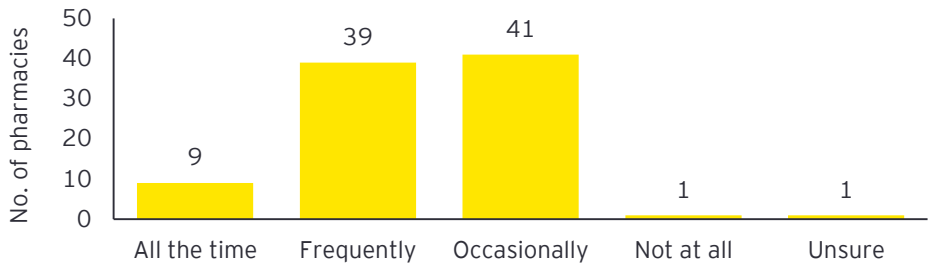


Figure 15 – Additional requests for home delivery services

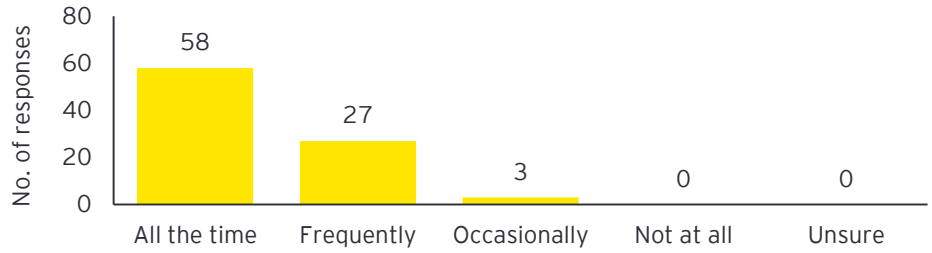
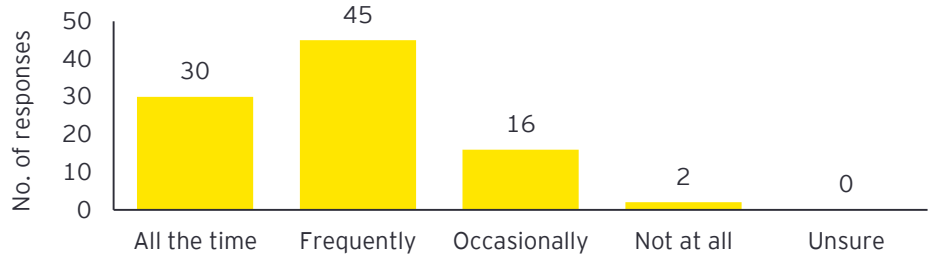


Figure 16 – Increase in patients seeking advice for minor ailments



Community pharmacy funding – Pharmacies rely heavily on the NHS for the majority of their funding – 87%

Community pharmacies are primarily funded through remuneration and drug reimbursement budgets

Community pharmacy is funded via multiple sources including NHS England, DHSC, CCGs and private services. Unlike other regulated industries and NHS services, pharmacies are not funded for service provision using prices based on fully loaded costs, but instead use lower marginal costs for services in addition to a combination of drug tariffs and capped retained margins for dispensing of medicines.

Remuneration from NHS England – £2.592bn (2018/19)

Under the 2019-24 CPCF, community pharmacies receive £2.592bn of funding, which includes £800m in retained buying margin (margins they are allowed to make on the difference between the cost of procuring medicines and the NHS reimbursement price). Funding is allocated to cover fees/allowances and advanced services (e.g., New Medicine Services).[25]

NHS funding represents 87% of community pharmacy revenues based on our data collection.

Drug Reimbursement – c.£9bn

Community pharmacies in England are also reimbursed for total drug spend (Drug Reimbursement), which historically has been around c.£9bn per year and is paid out via CCGs. [25]

Retained Buying Margin – £800m (per annum)

Community pharmacies are permitted to earn retained margin on the medicines they procure on behalf of NHSE. This has been set at £800m per annum and forms part of the Remuneration annual global sum (£2.592bn 2018/19), but is paid as part of the Drug Reimbursement budget (c.£9bn per annum).

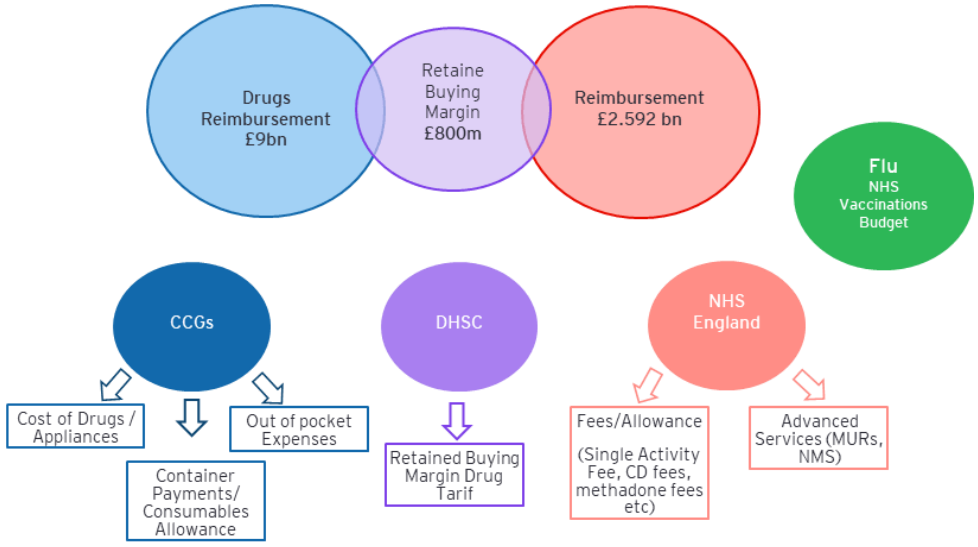
DHSC aims to deliver this target by adjusting the reimbursement prices of drugs in Category M of the Drug Tariff paid via CCGs.[25] This results in the drugs reimbursements received by community pharmacies fluctuating from year to year. Our understanding based on interviews is that an umbrella approach does not take into account factors such as:

- Heterogeneous dispensing mix (e.g., proportion of brands vs. generic drugs).
- Variation across local prescribing policies (e.g., branded generic prescribing, extending treatment periods, switching to cheaper brands).

Other budgets

In addition to the core funding components, there are separate budgets to cover NHS services delivered by community pharmacies that form the overall funding they receive. For instance, flu services are funded from the NHS vaccinations budget. Local services could be funded either through local authorities or CCGs. However, these are mainly funded through local authorities.[25]

Figure 17 – Community pharmacy funding arrangements



Source: Adapted from National Pharmacy Association, Community Pharmacy Funding Overview

Community pharmacy funding – There are a number of services for which pharmacies are paid a set fee

Advanced services under Community Pharmacy Contractual framework (CPCF)

In addition to dispensing and providing consultations, community pharmacy 'contractors' are commissioned to deliver a number of additional services, which include medicines management (New Medicines Service, Appliance Use Review), and Flu vaccinations.

Under the current CPCF, community pharmacies receive £2.592bn per annum, which includes budget for delivering essential and advanced services. This is also includes an estimated £800m of margin earned from buying medicines.

Examples of advanced services under CPCF

NHS Community Pharmacy Consultation Service (CPCS)

The NHS CPCS provides an access point for patients requiring treatment for minor illness or urgent supply of medicine. The unit cost of service is £14 per completed consultation when delivered by a community pharmacist.

New Medicine Service (NMS)

NMS supports individuals with long-term conditions (LTCs) that have been prescribed a new medicine in order to support medicine adherence. The price paid under the CPCF for delivering this service is between £20–£28 dependent on meeting targets per month for successful completion.

Medicine Use Review (MUR)

MURs are face-to-face consultations aimed at improving the knowledge, medicinal use and patient adherence to medicines through pharmacist-led review. The unit price for delivering this service is £28, but is limited in terms of volume of activity. Under the CPCF, community pharmacies are limited to 250 MURs in 2019/20 reducing to 100 in 2020/21 before being phased out at the end of the year.

Appliance Use Review (AUR)

AURs include face-to-face consultations aimed at advising patients on appropriate and safe methods to use, store and dispose of used and unwanted appliances. Such services can be carried out by a pharmacist or specialist nurse in a pharmacy premise or at a patient's home. The unit cost is £28 when delivered in a pharmacy premise and £54 when delivered in a patient's home. Contractors are paid £54 for the first AUR when more than one review is delivered in the same location.

Flu Vaccination Service

Eligible patients, mostly those with increased risks of ill-health are able to receive their flu vaccination at the cost of the NHS. Under the CPCF, contractors are paid £9.58 per administered vaccination, which includes an additional fee of £1.50 per vaccination recognising training and clinical waste costs.

Figure 18: Examples of prices paid for services under CPCF

Service type	Price paid by NHSE
New Medicine Service (NMS)	► £20–£28 depending on utilisation.
Medicine Use Review (MUR)	► £28 per MUR but limited volume of activity.
Appliance Use Review (AUR)	► £28 for an AUR conducted on pharmacy premises or £54 when delivered in patient's home. ► £54 paid for first AUR and £28 thereafter if multiple services are provided in same location within.
Flu Vaccination Service	£9.58 per administered drug + vaccine cost at list price.
NHS CPCS	► £14 per completed consultation.

Source: PSNC, Advanced Service payments[26]

Community pharmacy funding – Pharmacy service fees are significantly lower than for other similar services

Benchmark price for key activities across community, primary and secondary care settings

There is a stark difference in the price paid for key activities that community pharmacies deliver when compared against similar services performed by other healthcare professionals.

Benchmark price for key activities across community, primary and secondary care settings

Primary care

Within primary care, providers such as GPs receive a list-based payment to deliver consultations and akin services. These are funded through CCGs, and are not sensitive to the level of activity carried out. On average, the cost of an 11-minute GP face-to-face consultation was £30–£45 whilst the cost at an accident and emergency department was up to £128.[27, 28]

Secondary care

Within secondary care, consultations are reimbursed on the basis of the National Tariff, which includes fully loaded costs to delivering services.[29]

Service comparisons

A majority of the advanced services provided by community pharmacies are analogous to those performed in a GP consultation or outpatient setting within the NHS. For reference, some examples of list prices paid under the national tariff or the cost of delivering a selection of those services are provided in figure 19.

Limitations

The analysis was limited in its ability to drill down into detail of NHS payments to draw cost comparisons for direct services. For example, the analysis did not determine the cost or price paid for administering a vaccine in a GP or hospital for a direct comparison, and rather highlights the scale of difference in payment levels.

Figure 19 outlines different types of consultations, which broadly involve an average 10 to 20 minutes of face-to-face time between a clinician and patient. Such services will include potential for a minor procedure (e.g., such as blood tests), whilst major procedures are excluded and categorised differently within the National Tariff workbook. The average cost of GP consultation ranges from £30 for a 10 minute GP appointment through to £188 for areas such as infectious diseases, which may involve some testing or minor procedure.

Figure 19: Examples of average price and cost of services delivered outpatient settings[29, 30]

Service type	Price for first attendance with single professional		Follow-up with single professional
	Non-consultant led* (usually a nurse)	Consultant led	Consultant led
GP appointment	£30–£45		–
Dermatology	£87*	£125	£67
Pain management	£104*	£197	£80
General Medicine services	£107*	£180	£100
Infectious Diseases	£188*	£326	£134

* Taken from 2017-18 NHS Reference Cost guide[30]

Price Regulation System – Regulation of pharmacy is inconsistent with key principles

Price regulation system for pharmacies in England

The way remuneration is designed for pharmacies in England is inconsistent with other price regulation in the NHS and other regulated industries.

Price regulation principles

Regulation is typically introduced in markets in which there is limited scope for competition, thus a lack of incentive for further investment. Such markets require independent economic regulation over the long-term to protect consumers and ensure the provision of services is efficient and of adequate quality.

Regulators typically place a price ceiling on the amount that dominant organisations can charge consumers in order to promote efficiency and service quality, whilst ensuring that the market is a viable investment for incumbents.

Principles for effective economic regulation

In 2011 the UK Government outlined a set of principles for effective economic regulation[31]:

- Regulations that are **independent** and take place within a framework of duties and policies set by an accountable governmental body.
- Statutory responsibilities that have **focus** and are clearly defined, articulated and prioritised.
- A regulatory environment that is **predictable** enough to support investor confidence related to decision making.
- Regulation with enough capacity to **adapt** to changing environments over time.
- Regulations that are **efficient** and maximise the benefit they can deliver within given budgets and pose costs that are proportionate across the market.

It is recognised there are instances in which principles will conflict one another and a blanket approach might not be desirable in practice.

Learnings from price regulation elsewhere in healthcare and other markets

- **In healthcare,** NHS trust prices are set by the National Tariff, which is a price list based on fully loaded costs.[29]
- **In Aviation,** the investment costs of maintaining, replacing and enhancing assets is fully funded by 'full cost + margin' passenger charges (e.g., Heathrow airport).[32, 33, 34]
- **In Telecoms,** Openreach embed fully loaded costs in their price to consumers whilst making a return on investment.[35, 36]
- **In Water,** Ofwat, the regulator sets a ceiling on expenditure budgets based on historical data and any excess costs are shared between water companies and customers.[37, 38]
- **In Transport,** Network rail costs are recovered through a mix of direct grants from government and charges on train operators.[39, 40, 41]

Figure 20: Inconsistencies with community pharmacy

Economic regulation principle	Inconsistencies with effective economic regulation
Predictable	A number of services are commissioned locally by CCGs and local authorities. Interviewees have reported there can be a large degree of uncertainty as to whether these services will continue. This makes it too difficult for pharmacies to justify investing in staff and equipment – even when the margin is appealing.
Efficient	For locally commissioned services, interviewees consistently reported the processes can be onerous and time consuming with procurement often delayed, cancelled and re-issued. This acts as a further barrier to pharmacies providing services.
Independent	There is no independent financial regulator within the community pharmacy network. This risks NHSE as a monopsonist purchaser setting funding and pricing mechanisms that do not support a sustainable network.

Community pharmacy lacks an independent price regulator and prices are currently set in a manner which is inconsistent with independently regulated markets.

Policy and funding – Summary

The English health system and the Long Term Plan

- Funding flows from HM Treasury through to the Department of Health and Social Care, which is split across several health organisations who commission services.
- The Long Term Plan (2019) sets out key long term priorities for the NHS. These include improving services across primary and community based settings, improving resource allocation and addressing workforce challenges in addition to system priorities to integrate care and reduce inequalities.
- LTP represents a significant shift in ambition with movement away from traditional models of care requiring significant structural changes from all health disciplines to develop roles moving forward driven largely by the move to integrated care.
- Significant changes in role of community pharmacy are likely as LTP is implemented which will require resources to service, partly afforded by efficiencies through dispensing practices.

International benchmarks

- Benchmarking suggests a higher proportion of Pharmacy workforce, relative to other disciplines, potentially indicating pharmacy is in a stronger position to respond to delivery of new services to support a stretched health service in the changing landscape.
- However, there is evidence to suggest that further expansion of the role of community pharmacy may be difficult to accommodate given the breadth of existing services provided and shrinking margins on core activities including dispensing.

Value of community pharmacy in England

- Community pharmacies are key contributors to the sustainability of the NHS through essential and enhanced services, urgent and preventative care.
- Utilising pharmacy is seen as a key way to reduce burden in other stretched parts of the health system.

Value of community pharmacy in England cont.

- The value added by pharmacy will increase in line with LTP ambitions. Additionally, the role of pharmacy in managing external factors such as COVID-19 are also demonstrating the agility of pharmacies in times of crisis.
- Pharmacies are deemed by patients as a favourable provider from which to receive healthcare services. Results from a survey carried out by NPA showed that community pharmacies were more favourable than GPs and other healthcare professionals demonstrating the value to the public.
- Opportunities are available to continue to build the brand of pharmacy as an increasingly valued and differentiated healthcare service.

Community pharmacy funding

- Community pharmacy is funded via multiple sources including NHS England, DHSC, CCGs (though local authorities) and private services. Unlike other regulated industries and NHS services, pharmacies are not funded using fully loaded costs, but a combination of drug tariffs, fees, allowances and reimbursements.
- Hence, there is no easy way to demonstrate that the pricing for services will cover costs for individual pharmacies unlike other tariff based payments in the NHS.
- This may explain the significant difference in the price paid for services community pharmacists deliver when compared to similar services provided by other health professionals indicating pharmacy may be significantly undervalued.

Price regulation system

- The price regulation system for pharmacies in England is inconsistent with other price regulation in other parts of the NHS and other regulated industries.
- Community pharmacy lacks an independent price regulator and prices are currently set in a manner which is inconsistent with independently regulated markets.

4

Current state of the network

Current state of the network — Independent community pharmacy makes up around half of the English pharmacy network

Overview

According to 2018/19 data, there are 11,539 community pharmacies in England.[42]

Our research sample includes 105 premises across England. The financial data collected does not include the impact of COVID-19 as financial accounts for FY2020 have not yet been prepared. Instead, stakeholder interviews have provided qualitative evidence of the impact of COVID-19.

Our sample

We collected data from 105 premises across England including:

- 58 in cities
- 38 in towns
- 6 in villages
- 3 in other/undefined

Clusters

The sample includes 58 single premises, 8 clusters with 2 premises, 2 clusters with 3 premises and 5 clusters with 4+ premises.

Plans to sell pharmacies

Of all respondents, 30% stated soft plans to sell their pharmacies, 22% reported firm plans to sell, of which 5% had a sale in progress. Just 4% of respondents did not provide a response to this question.

Figure 21 — Location of respondents

Current state of the network – A considerable proportion of sampled community pharmacies are in financial deficit

Financial trends

Our sampling of the network showed 28% of the respondents were in deficit in 2019. We can see this was primarily driven by increasing costs and declining revenue.

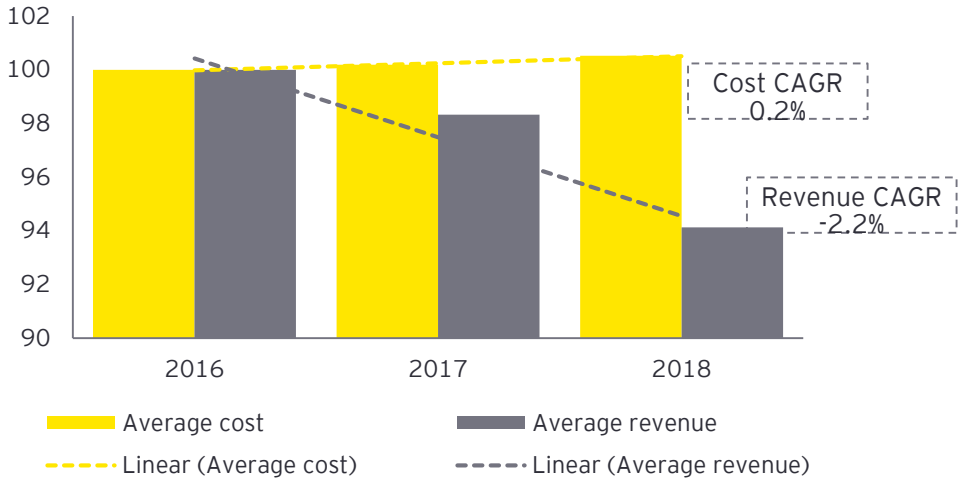
Increasing costs

Community pharmacies have experienced a marginal increase in costs in the years leading to 2018/19, growing steadily at 0.2%. Interviewees have suggested community pharmacy owners have exercised cost-containment strategies which have involved cutting staff/staff hours and taking on a greater workload as the business owner to achieve these relatively flat costs, and that this is not sustainable long term.

Revenue has stagnated

Community pharmacies have not experienced the same trajectory in revenues as they have in costs, with revenues declining at -2.2% each year on average.

Figure 22 – Average total cost and revenue per premise

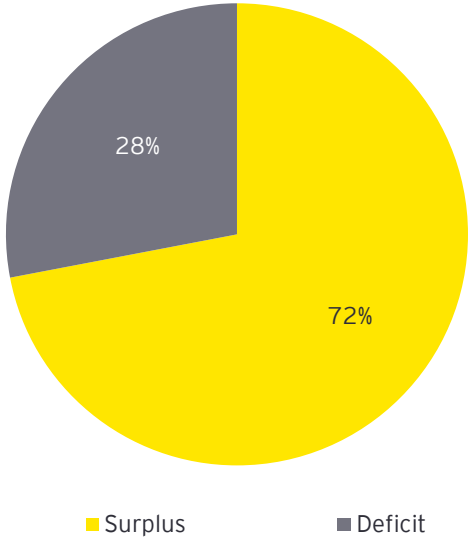


Surplus/Deficit

Approximately 28% of respondents reported to be in deficit for FY2019. The average surplus/deficit in this year was £78k.

It should be noted that comparison to other data sources suggests our sample may be skewed towards pharmacies with a higher than average surplus. For example, our analysis with the GPhC suggested that for sole premise independent pharmacies, the average surplus was £25k in 2018, with 38% of the network in deficit, as explained in more detail overleaf.

Figure 23 – Proportion of respondents in surplus/deficit 2019



Current state of the network — The true state of the network may be significantly worse than our data collection suggests

Random sampling and publicly available data

We previously undertook an analysis of the whole community pharmacy network for Great Britain on behalf of the GPhC. This utilised a random sampling approach and publicly available financial data from companies house. This analysis is based on 2018 data and suggests a significantly worse position than the results of our primary data collection.[43]

Spread of surplus/deficit positions

- At an individual company level deficits varied greatly in this dataset.
- At an average premise level, multiples exhibited higher surpluses than sole premise businesses, while isolated sole premise businesses were loss making on average. Overall the larger multiples exhibited a higher average surplus than the smaller multiples.
- Across the network the weighted average surplus by premise was £25k — significantly lower than the £78k identified by our primary data collection exercise.
- The weighted average proportion of organisations in deficit was 38% — again significantly worse than the 28% identified through our primary data collection exercise.

Understanding the differences

The data we collected through our primary data collection tool was reviewed and cleaned, with erroneous date removed. Despite this the average surplus and proportion of the network reporting deficit remained reasonably constant.

For smaller multiples and sole premise businesses, the data collected from companies house often did not include an income statement, and as such surplus/deficit was calculated based on movements in shareholder equity.

This could explain the differences reported, as we understand it is common practice for owners of pharmacy businesses to pay themselves at least in part via dividend rather than salary, which would be accounted for in shareholder's equity but not the income statement. In effect the difference is the exclusion of part of the owner's renumeration from the primary data collection exercise.

Figure 24 — GPhC analysis of network deficit (2018)

Strata	Number of premises	Sample size (orgs)	Sample size (premises)	Combined surplus/ (deficit) (£k)	Surplus/ (deficit) per premise (£k)	Estimated network surplus/deficit 2018 (£k)	Weighted average surplus/ (deficit) per premise (£k)	% of sampled organisations in deficit	Weighted average % of organisations in deficit
LPCs (9+ premises)	8,236 premises owned by 81 companies	5	5,424	166,201	31	252,366	NA	40%	NA
MPCs (2–9 premises)	2,766 premises owned by 944 companies	10	18	350	19	53,859	NA	40%	NA
SIPs (1 premise, not isolated)	3,208	10	10	173	17	55,386	NA	30%	NA
ISIPs (1 premise, isolated)	103	10	10	-178	-18	-1,834	NA	70%	NA
Total	**14,313**	**35**				**359,776**	**£25k**		**38%**

Current state of the network – Community pharmacies predominantly rely on NHS income

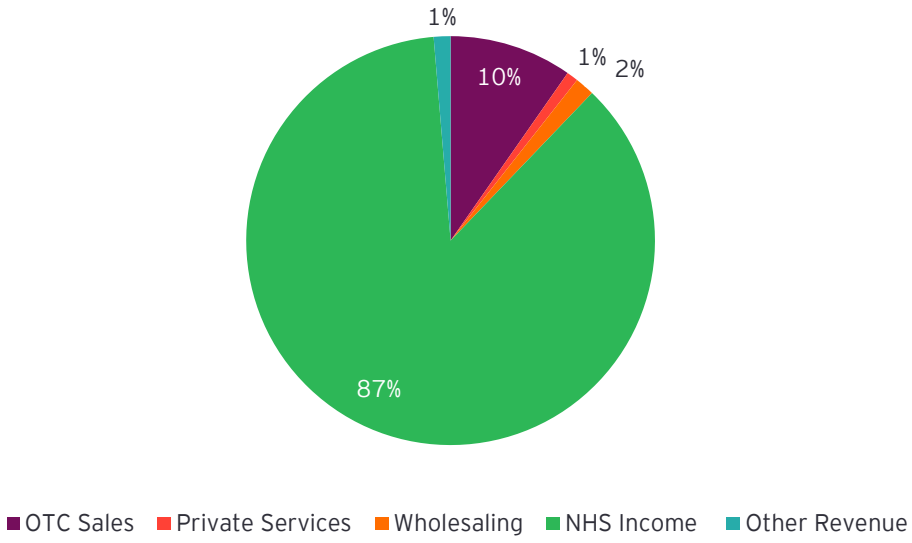
Financial breakdowns

Costs and revenues of community pharmacies are predominately driven by the purchasing of prescription medication and the reimbursements made by the NHS to pharmacies for dispensing.

Revenue breakdown

NHS income on average accounts for approximately 87% of total revenue, reflecting the revenues achieved from drug reimbursements. By contrast, over the counter medicines account for 10% of revenue, whilst private services reflect just 1% of revenue. Local services (such as smoking cessation), captured within NHS income, accounts for just 1% of total revenue.

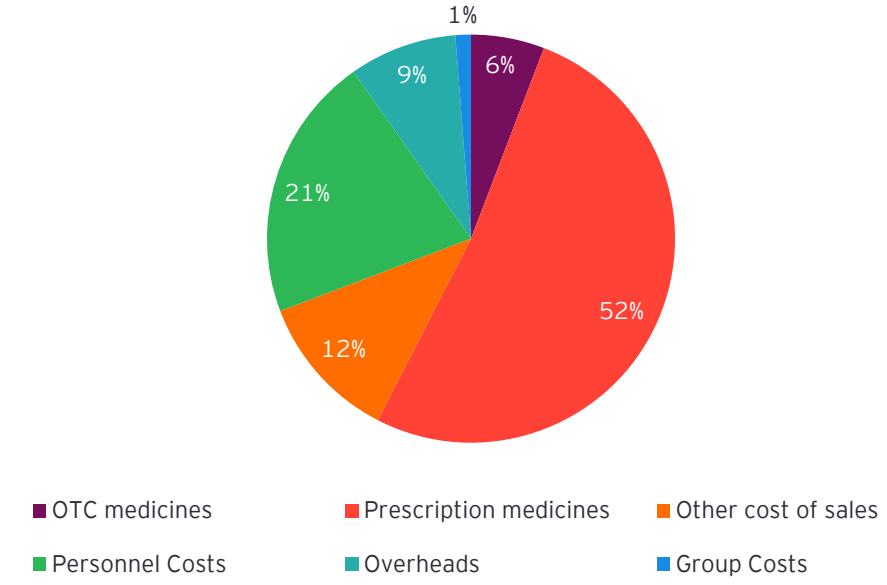
Figure 25 – Revenue breakdown 2018/19



Cost breakdown

Cost of sales for community pharmacies include over the counter medicines, prescription medicines and other costs of sales. Expenses include personnel costs, overheads and group costs. The majority of costs (52%) are attributed to prescription costs. This is then followed by the cost of personnel (21%).

Figure 26 – Cost breakdown 2018/19



Current state of the network – Financial constraints have stopped sampled pharmacies from offering more services

Overview

Community pharmacies provide a range of public health services alongside dispensing services. Approximately 87% of respondents reported they can not afford to take on more staff to deliver new or additional services.

Service offering

The most common service offerings reported by respondents included:

- Emergency Hormonal Contraception (64%)
- Supervised consumption (61%)
- Smoking cessation (39%)
- Sexual health (34%)
- Minor ailments (35%)

Drivers contributing to insufficient capacity to deliver new services

Respondents highlighted capacity constraints of current staff (71%) and inability to take on new staff due to financial pressures (87%) as key constraints preventing them from offering new services.

Reasons for stopping home delivery services

Of the respondents who reported they had ceased home delivery of medicines, all highlighted financial pressures and 91% suggested staff shortages as a reason for this.

Figure 27 – New services capacity constraints

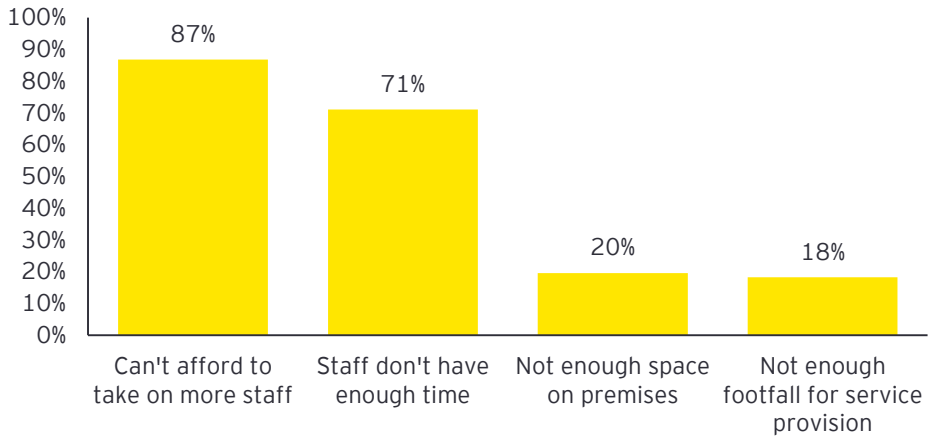
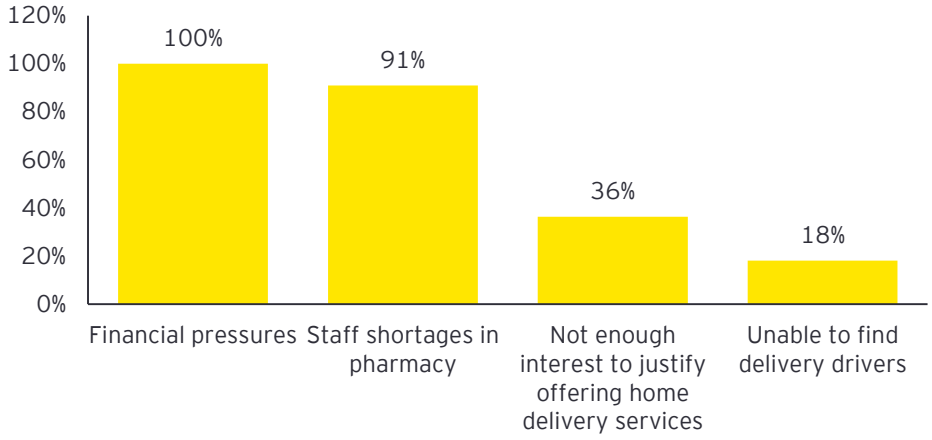


Figure 28 – Home delivery capacity constraints



Current state of the network – Summary

Within our sample of 105 pharmacies we found:

- 28% of the respondents were in deficit in 2019. This was primarily driven by declining revenue.
- 52% of respondents planned to sell their premise, with these being firm plans for 22%.
- Costs and revenues of community pharmacies are predominately driven by the purchasing of prescription medication and the reimbursements made by the NHS to pharmacies for dispensing.
- Community pharmacies provide a range of public health services alongside dispensing services. Approximately 87% of respondents reported they can not afford to take on more staff to deliver new or additional services.

Comparison with previous analysis

- Previous analysis we undertook from the GPhC, based on publicly available data and stratified random sampling, suggests the financial position across the network may be worse than our primary data collection exercise suggests.
- That work found that across Great Britain, the weighted average surplus by premise was £25k – significantly lower than the £78k identified by our primary data collection exercise. It estimated that that 38% of premises were in deficit by 2018, as opposed to the 28% our primary data collection estimated for 2019.
- To put the £78k into context, this is before a number of costs are accounted for and does therefore not represent the true profit figure for the pharmacy. From this £78k the pharmacy owner will often take their salary (rather than paying themselves as an employee) and they must make a provision for a personal pension. Notional overtime payments for work conducted outside a theoretical 40-hour working week, an allowance for the cost of capital employed within the business and corporation tax should be considered. Pharmacy owners that own their building should take a notional rent before the net profit figure is determined. The £78k is neither an operating profit nor is it the net profit for the company. Given the vast majority of owners in the independent pharmacy network are working pharmacists, this would suggest that the more appropriate estimate of the true financial position of community pharmacy is the £25k surplus per premise and 38% of the network in deficit.
- It is also worth noting that whilst interest payments on loans will be captured in the income statement, the repayment of the capital on loans will not, and will represent another cash pressure on businesses.

The NPA ran an additional survey for its members to understand the extent to which owners paid themselves via dividends in order to test this explanation. It found that dividends range from 0% to greater than 100% of salary (2x salary). Respondents also identified that they do not receive NHS pensions, making private pension provision or relying on a state pension.

5 Impact analysis

Impact analysis – Lower turnover and high cost of sales drive high proportion of deficit

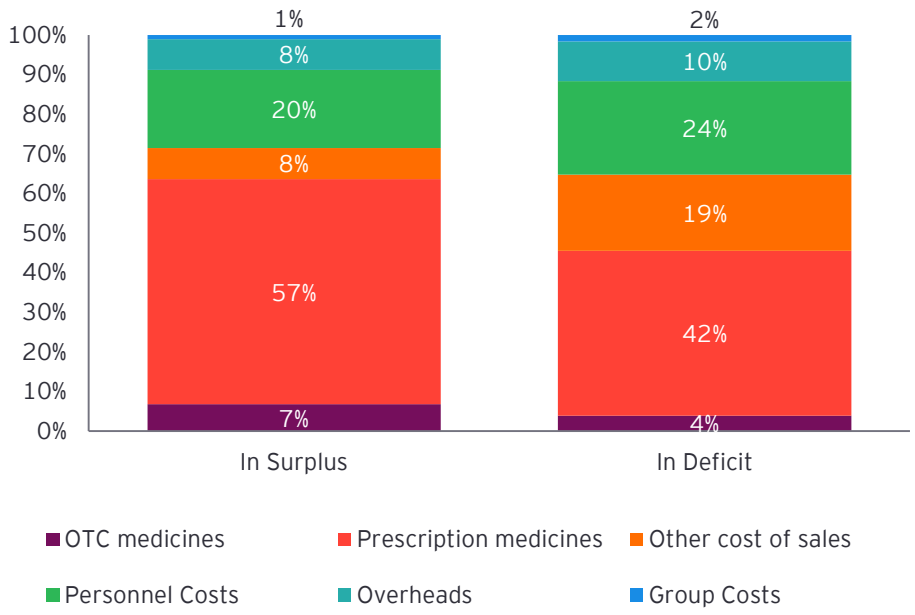
Financial factors

Respondents found to be under the most financial strain reported significantly higher costs of sales and higher proportion of branded prescriptions. Those with lower levels of revenue were more likely to be in deficit in 2018/19.

Cost comparison

Independent pharmacies in deficit had a high proportion of reported cost of sales and higher overheads.

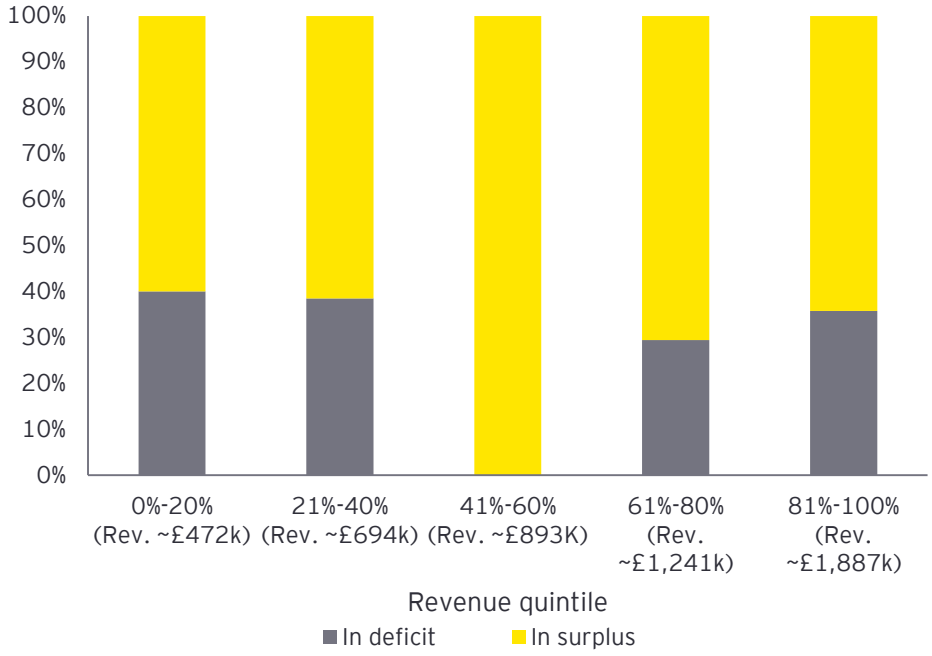
Figure 29 – Cost breakdown (2018/19)



Revenue comparison

Deficit was reported marginally more frequently in independent pharmacies with lower levels of revenues compared to pharmacies with higher levels of revenues, although those with average revenues had the lowest proportion of deficits, which may suggest step costs after a certain scale is reached. This appears to contradict the notion of a linear relationship between scale and efficiency at a premise level.

Figure 30 – Scale of revenue comparison (2018/19)



Impact analysis — Similar levels of single premise and multi-premise pharmacy owners reported deficits

Operational factors

Operational factors such as staffing mix and ownership structure varied little between those reporting deficit and those reporting surplus in 2018/19.

Staff mix

Staff mix was comparable between those in deficit and those in surplus in 2018/19. However, those reporting a surplus had a higher proportion of pharmacists and dispensary staff.

Part of a group

Of premises reporting a deficit, 48% were part of a group (multiples) while 52% were sole owned.

Figure 31 — Ownership structure comparison (2018/19)

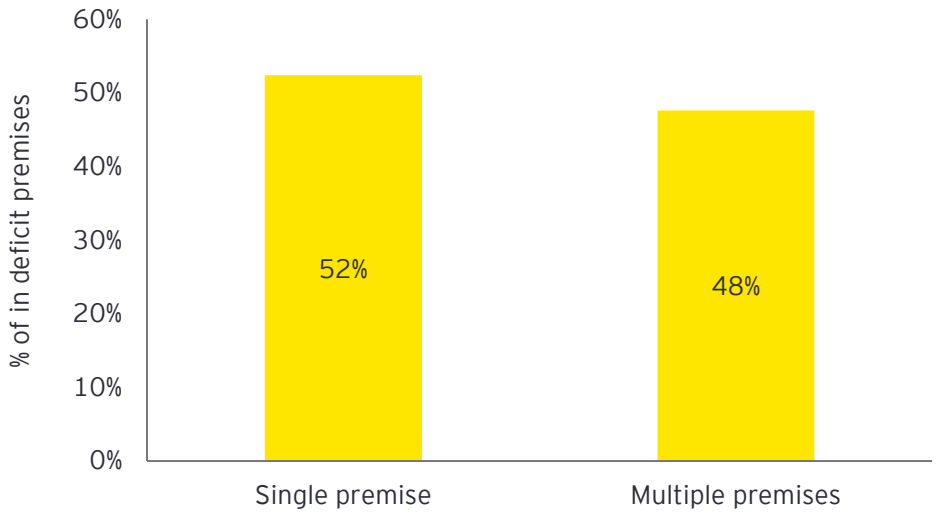
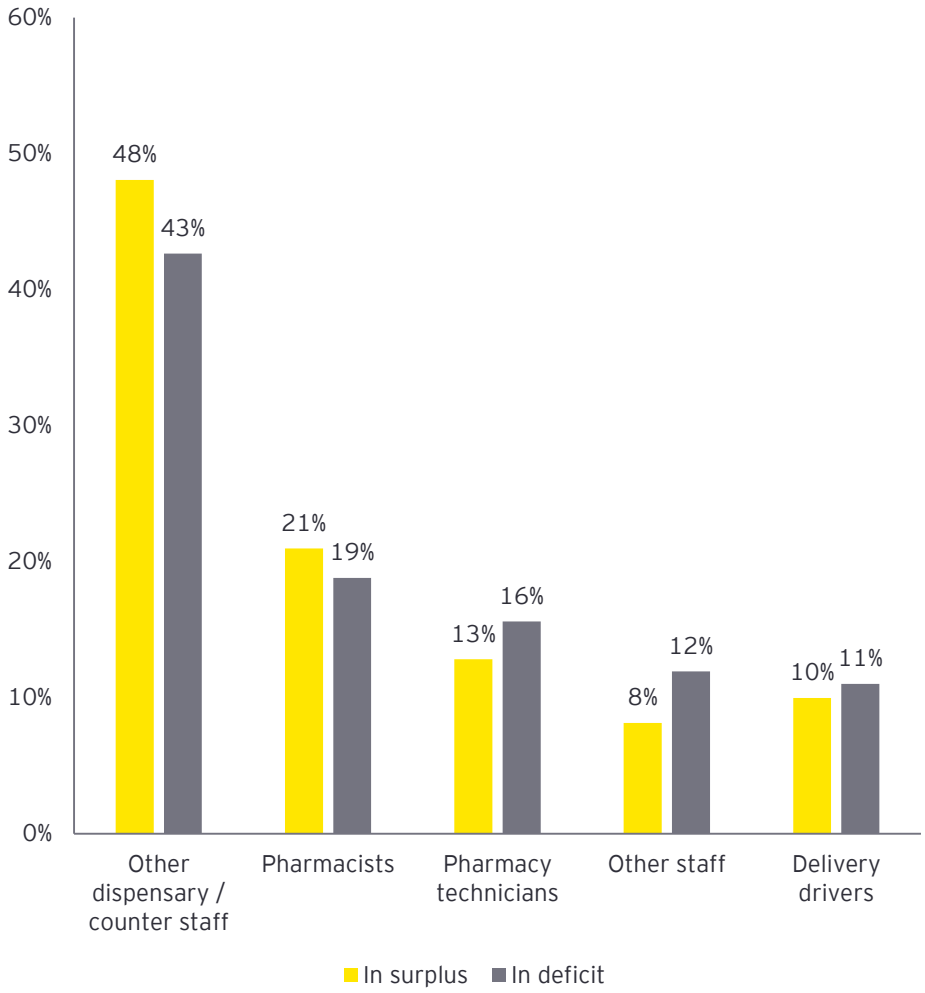


Figure 32 — Staffing mix of those in deficit in 2018/19 (FTE)



Impact analysis – Longer operating hours and high proportion of branded prescriptions drive deficit

Dispensing and operating hours

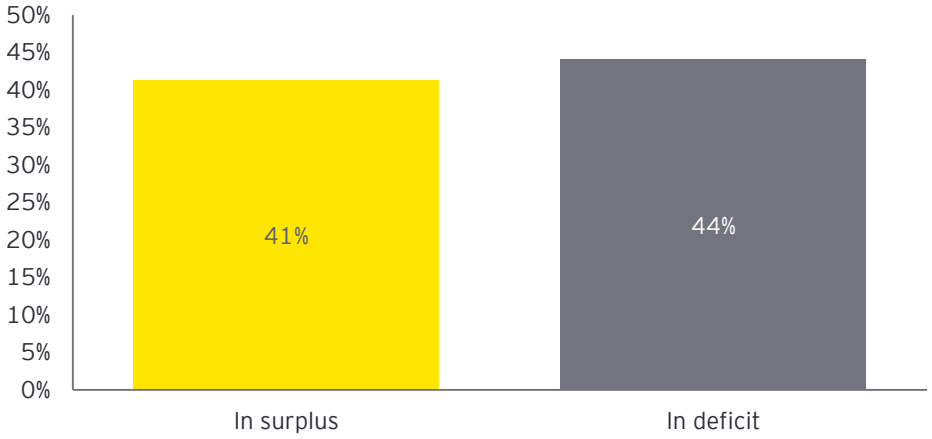
Those in deficit reported a higher proportion of branded medicine prescribing mix (44%) compared to those in surplus (41%). Those in deficit also reported to have operated well above average operating hours of those in surplus (57 hours compared 51 hours).

Brands vs. generics

Those in surplus reported 41% of total prescription volumes to be branded medicines, whilst this figure was higher at 44% for those in deficit.

Interviewees suggested that community pharmacies have little control over their branded/generic mix beyond a certain point, and as such this may suggest factors outside of their control may play a significant role in determining financial performance.

Figure 33 – Average proportion of prescription volumes branded medicines (2018/19)



Opening hours

Average operating hours of respondents was ~53 hours per week. Those in surplus had a higher proportion of respondents open below average hours, with an average opening time of 51 hours per week. The average opening hours for those in deficit was 57 hours per week, with ~63% of those in deficit operating above average hours.

Figure 34 – In surplus/deficit average hours variation

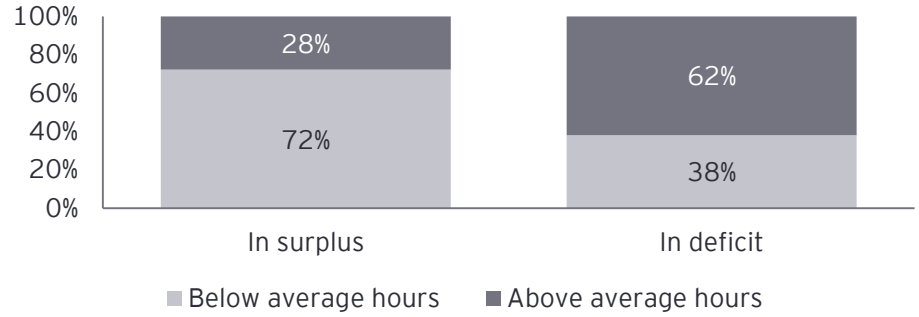
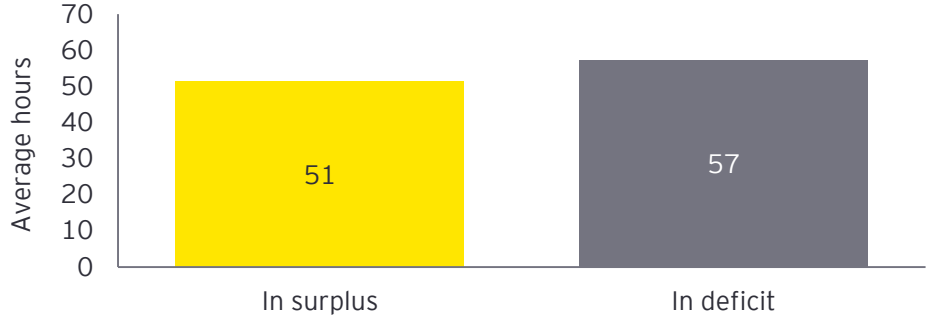


Figure 35 – Average opening hours comparison



Impact analysis – Services make up a very small proportion of total income

Services

Services make up a very small proportion of total income for both those in surplus and those in deficit. However, those in surplus reported lower income from services (0.5% in local services and 0.6% in other services compared to 0.9% and 0.8% respectively).

Services

Services uptake was reported to be particularly low across all pharmacies, making up only a very small percentage of total revenue.

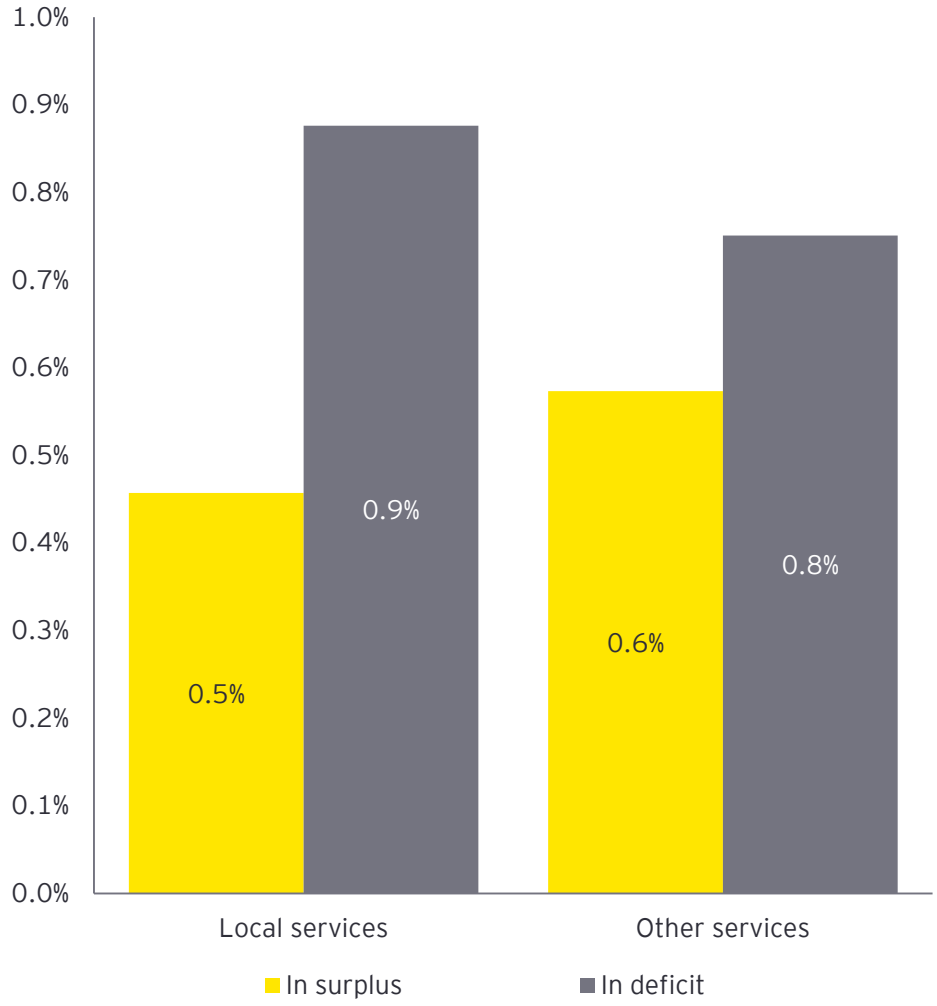
Local services included those commissioned through local authorities such as emergency hormonal contraception (EHC) and supervised consumption. Other services included income received through flu vaccination, the pharmacy access scheme and transitional payments.

Anecdotal evidence received through stakeholder interviews has suggested a lack of certainty in the commissioning of services creates challenges to maintain commercial viability.

The cost of training staff and maintaining trained staff for services was also highlighted as a concern which is further exacerbated when the lifespan of a commissioned service is uncertain.

Worse financial performance for premises that provide a higher proportion of services, suggests these services do not provide a sufficient contribution to be financially viable, which aligns to our finding of low prices compared to those received in other healthcare settings.

Figure 36 – Services income as % of total income



Impact analysis – Year on year trends indicate average costs rising by 0.2% whilst revenues fall by -2.2%

Projecting future trends

Trend analysis estimates pharmacies are moving closer towards an average deficit. With high degree of variation in the network, average deficit/surplus was estimated to range between -£37,652 and +£3,549 by 2024.

Method of trend analysis

Financial data of respondents was used to project future surplus/deficit in two methods:

- Estimating a network trend for 2016-18* (CAGR) in costs of revenues and applying that trend across all individual premises.
- Estimating an individual trend for 2016-18 (CAGR) for each premise and applying those trends to each individual corresponding premise.

Following network trends

Year on year growth in total average cost across respondents was estimated to be 0.2%, whilst total average revenues was estimated to decline year on year by -2.2%. This estimated an average deficit in 2024 of -£37,652.

It should be noted considerable cost cutting taken in recent years may limit pharmacy owners' ability to continue containing costs in future years at 0.2% and a more realistic scenario may include greater growth in costs.

Individual premise trends

A high degree of variation was found across premises. Year on year change in average total cost was between -9% and +27% for individual pharmacies, whilst revenues showed a year on year change of between -18% and +17%. This estimated an average surplus of £3,549.

Figure 37 – Average cost/revenue (network trend)

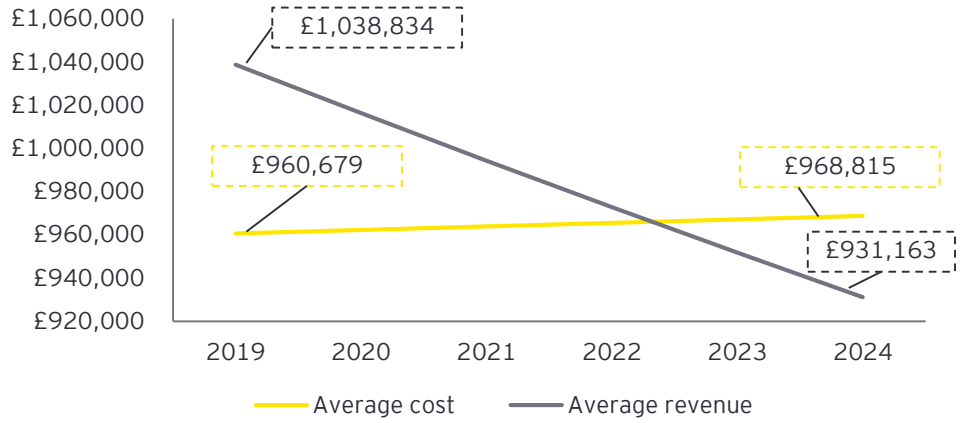
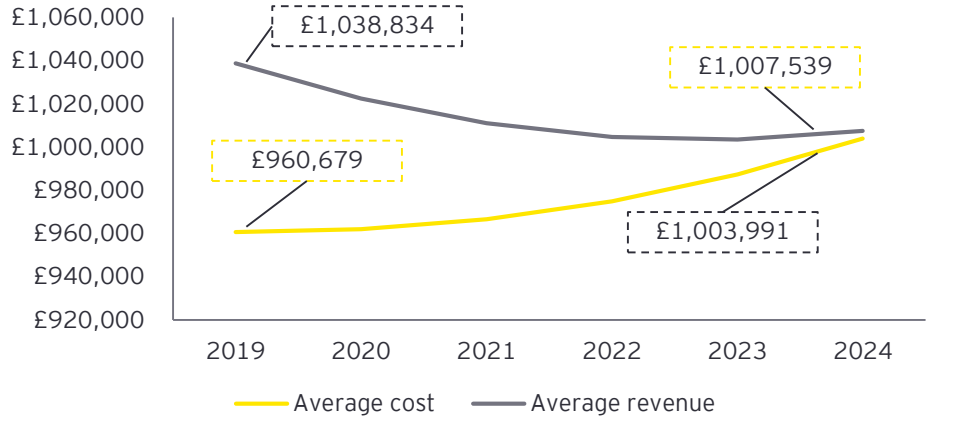


Figure 38 – Average cost/revenue (individual trend)



* 2018/19 data was not used to estimate trend due to limited data availability.

Impact analysis – Should current financial trends continue, approx. 64-85% may be in deficit by 2024

Projecting future deficits

Approximately 28% of respondents were estimated to be in deficit in 2019. Projections indicated this figure to grow to between 64-85% in 2024.

Future deficits under three scenarios

Future deficit was estimated using trend analysis under four scenarios:

1. Individual trends: Assumes costs and revenues follow year on year trends of individual premises.
2. Network trend: Assumes costs and revenues to follow average network year on year trends.
3. Network trend (adjusted): Assumes average surplus/deficit to follow average network year on year trend from an alternative baseline of £25,136 sourced from the GPhC.
4. Base case: Assumes current revenue levels to be maintained but costs to increase with expectation.

Growing proportion in deficit under all scenarios

All forecasts suggest a growing proportion of pharmacies moving towards a deficit through to 2024. The most optimistic scenario assumes 64% of pharmacies to be in deficit in 2024.

Stakeholder interviews and other sources of network data have suggested average surplus/deficit collected in this study is overestimated. Using an alternative baseline of network surplus/deficit, approximately 85% of pharmacies are estimated to be in deficit in 2024.

Figure 39 – Average surplus/deficit

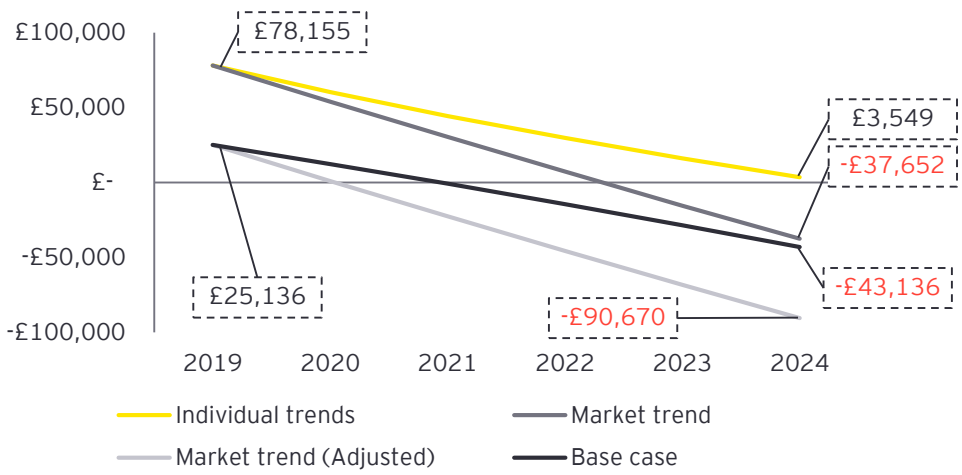
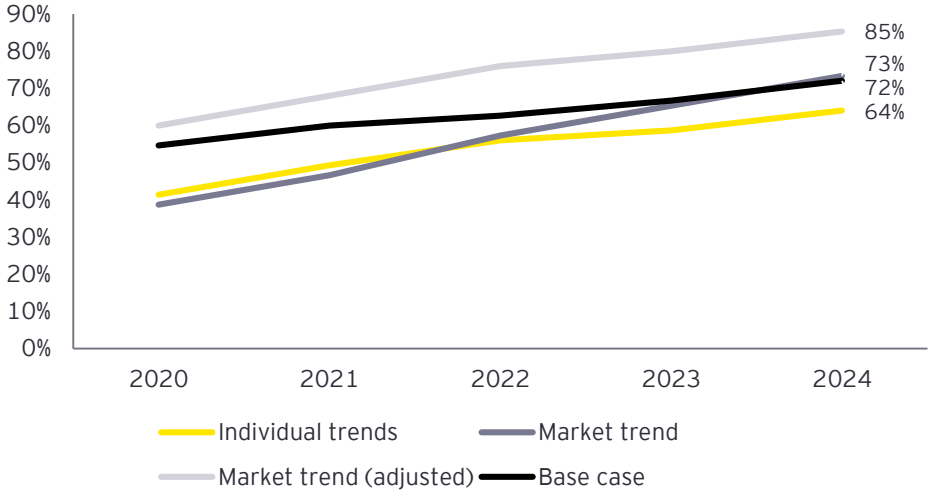


Figure 40 – Forecast proportion of respondents in deficit*



Impact analysis — Our base case scenario projects 72% of pharmacy premises in deficit by 2024

A growing proportion in deficit

A base case scenario utilising more detailed assumptions on expected movements in costs and revenues suggests 72% of the network to be in deficit by 2024.

Maintaining revenues

The base case assumes revenues to be maintained at current levels as per the current CPCF. This assumes the NHS distributes promised funding each year.

Failing cost containment

Stakeholder interviews suggest that community pharmacies have sought to contain costs by reducing staff and owners have taken on greater operational responsibilities. Acknowledging this may not be sustainable, the base case assumes a rise in costs over the medium term in line with national rates of inflation or observed trends. This is with the exception of prescription medicine costs for which we have assume costs to fall slightly.

The below assumptions were made:

- **Prescription medicines:** are assumed to decrease in costs by − 0.2%. This is reflective of the average y/y % change (2016-19) in costs of primary care prescribing dispensed in the community (estimate sourced from NHS Digital). This is based on the historical volume and price of medicines.
- **Staff costs***:* average weekly wages in Health and Social Work rose by 3.4% when comparing January 2019 to January 2020. This growth is expected to continue and be influenced by policies such as the National Living Wage and increases to the minimum wage.
- **Other costs**: include OTC medicines, overheads and group costs. These have been assumed to follow RPI trend (2.7% − January 2019–20 y/y% change).

Non-dynamic modelling

Our approach to producing our projections (including the base case) is not dynamic − we do not model businesses closing and the knock on effect of this, but rather project forwards the network as it is (including being in its pre-COVID-19 crisis state) in order to determine the proportion of businesses in deficit and as such at risk of being unsustainable.

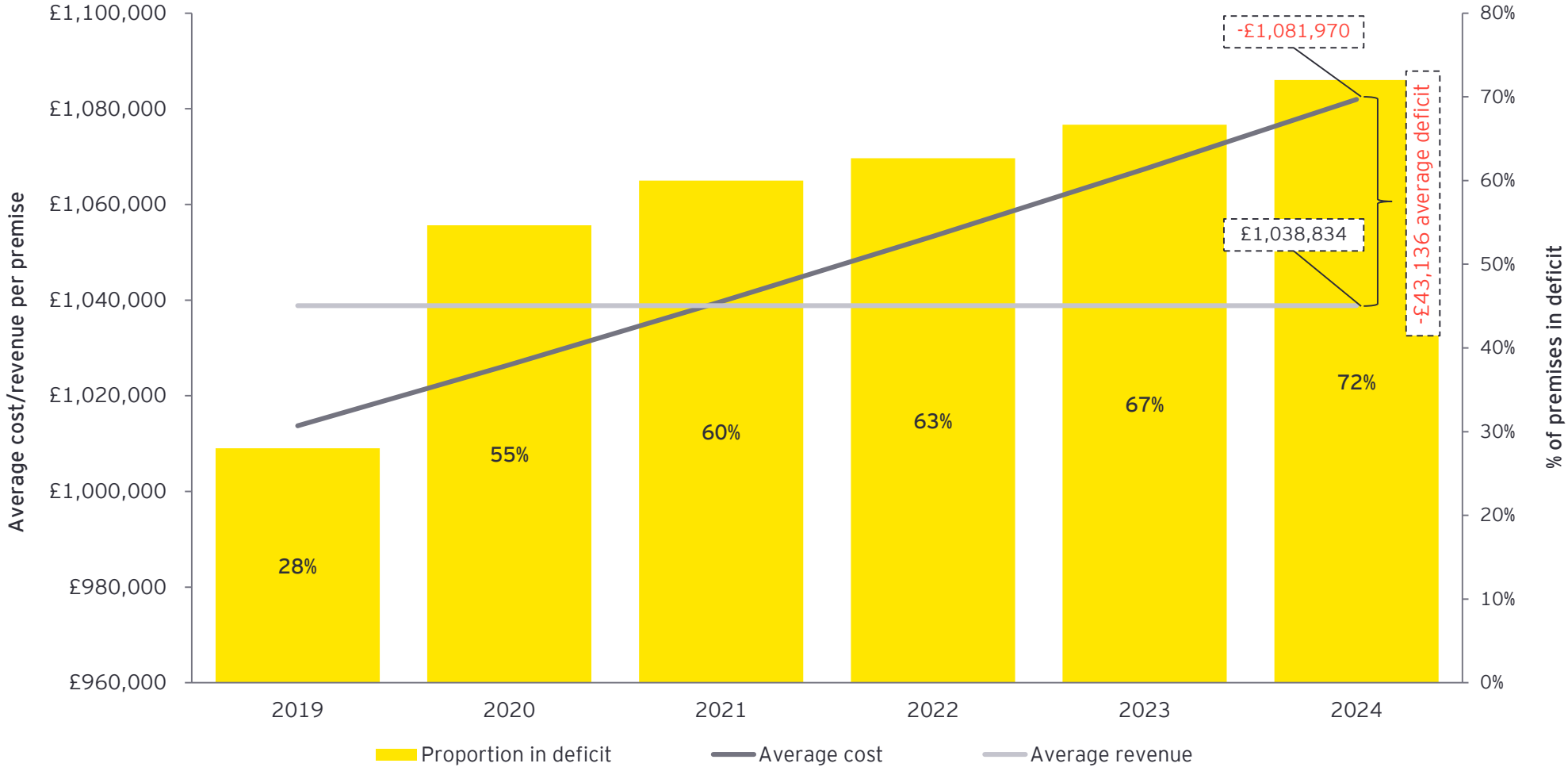
Outputs

Our base case falls within the range of our other scenarios. It predicts that by 2024 the average premise will face £43k deficit and 72% of the network will be in deficit. Across all projections average financial performance projections for 2024 range from £4k surplus to £91k deficit, with 64%–85% of the network in deficit.

Clearly these scenarios would not be financially sustainable, and would likely lead to a severe contraction of the network.

Impact analysis – Our base case scenario projects 72% of pharmacy premises in deficit by 2024 (cont'd)

Figure 41 – Base case average cost, revenue, surplus/(deficit) and proportion of premises in deficit



Impact analysis — Current conditions risk undermining affordable access to care

Potential ramifications

Current funding arrangements and economic conditions risk reducing access to care, constrain current healthcare service provision and may lead to increasing demand pressures on other healthcare providers. This then has further implications for patient quality of care and broader community health outcomes.

Access to care

Access to care may significantly decline should current funding arrangements and economic conditions persist.

A significant number of pharmacies were reported to be in financial distress in 2018/19. Network trends indicate a growing number of pharmacy premises moving into deficit under current funding arrangements and economic conditions. This includes a higher proportion of pharmacies operating longer than average hours.

This may undermine the objective of community pharmacy supporting urgent care, which by its nature requires longer opening hours.

Services of care

Under current conditions, community pharmacies are unlikely to offer a broader range of services.

Services provided by pharmacies receive lower tariffs than comparable services offered in other healthcare settings. Interviews with pharmacy owners have suggested a lack of certainty in commissioning for local services further constrains commercial viability of service delivery.

This has the knock on effect of reducing access to services in local communities.

Health system implications

Primary care networks (PCNs), sustainability and transformation partnerships (STPs), integrated care systems (ICSs), general practice clinics and hospital emergency departments would be left to manage the consequences should a significant proportion of pharmacies exit the network.

General practice and emergency departments may experience higher demand of services should there be a reduction in the density of community pharmacy in England. This would either drive higher costs in primary care, or reduce access to care should primary care be unable to expand.

Primary care in England is already under constrain. The current high density of community pharmacies in England present an opportunity to alleviate demand in other parts of primary care — particularly in the areas of public health and minor ailments. This has been seen in the experience of COVID-19 where community pharmacies absorbed unmet demand as primary care services failed to expand capacity (and in some cases, reduced access entirely). This policy option would be lost should a significant number of community pharmacies exit the network.

Medicines budget implications

The NHS relies on a large number of community pharmacies competing in the network for procurement of cheaper medicines to maintain competitive pharmaceutical prices. A mass consolidation of community pharmacies in England would limit the NHS' ability to maintain current medicines budget spend.

Impact analysis – Summary

01 Higher cost of sales and lower proportion of generics results in high deficits

Respondents found to be under the most financial strain reported higher costs of sales and higher proportion of branded prescriptions, which interviews suggest may be largely out of their control. This suggests that the mechanism for distributing retained margin may be inequitable.

02 Bigger does not appear to mean more financially sustainable

Operational factors such as staffing mix and ownership structure varied little between those reporting deficit and those reporting surplus in 2018/19. The segment of respondents with approximately average revenues had no premises in deficit (0%), while a significant proportion of respondents with below and above average revenues reported deficits.

03 Deficits within the network may disproportionately undermine NHS England's key objectives

Those premises which provide a larger proportion of services (based on proportion of revenue) and which have longer opening hours are more likely to be in deficit. This suggests the current funding model is undermining NHS England's vision of a more service based community model supporting urgent care and patients with long-term conditions.

04 Year on year trends indicate average costs rising by 0.2% whilst revenues fall by -2.2%

Trend analysis estimates pharmacies are moving closer towards an average deficit. With high degree of variation in the network, average deficit/surplus was estimated to range between -£37,652 and +£3,549 in 2024. It should be noted pharmacy owners have pursued a strategy of cost containment by taking on greater responsibility and reducing costs by reducing staff hours and head count.

05 Should current financial trends continue, between 64-85% may be in deficit by 2024

Approximately 28% of respondents were estimated to be in deficit in 2019. Projections indicated this figure to grow to between 64-85% in 2024.

06 Current conditions risk reducing access to care and increasing health inequalities

Current funding arrangements and economic conditions risk reducing access to care, constrain current healthcare service provision and may lead to increasing demand pressures on other healthcare providers. This may also lead to greater inequalities if wealthier customers are more able to access care through privately funded services.

Conclusion and recommendations

Key messages from stakeholder interviews

Stakeholder interviews

We tested the approach and validation/interpretation of findings within the report with a set of stakeholders through a series of group and individual interviews, which resulted in a number of key observations categorised below.

01 COVID-19

During COVID-19, the nature of the core of the work dramatically changed. Other parts of the health services started to limit access. Pharmacy faced additional demand because it maintained access during the crisis. It is unclear as to whether these changed demands might persist beyond the crisis or re-emerge if there is a second wave of COVID-19 cases.

02 Services / Pharmaceutical services

Services provided by community pharmacies heavily rely on where you are located because they are commissioned by CCGs and local authorities. The process of tendering to provide these services can be onerous and future pricing can be unpredictable, making tendering for them unappealing. There have been instances of just 48 hours being given to produce a tender.

03 Costs

Costs have been contained through efforts like cutting operating hours and many proprietors are working additional unremunerated hours as they can no longer afford to pay for appropriate staffing. Fixed costs have increased (wages, rents and rates). For other parts of the economy these can potentially be passed on, however in pharmacy there is a flat 5 year remuneration contract.

04 Prescribing mix

Pharmacies – both multiples and small independents – have limited ability to influence prices of drugs or generic/branded mix. Even within large multiples similar premises may have different financial performance based on the prescribing patterns and medicines policies of local CCGs. This flaw in the funding mechanism creates winners and losers based on geographic location of a premise.

05 Safety

Robotics and the use of automated processes has been suggested as a potential solution to reducing dispensing errors within pharmacy. Whilst robotics will ensure that the picking of drugs is safer, additional clinical activities that sit alongside are out of the control of robotics. This includes advice on drug interactions and dose checking. As such, robotics will not affect error rates in these areas.

06 Efficiencies

NHSE is investigating a hub and spoke model to drive efficiencies amongst community pharmacies. Interviewees suggested these models would not be more efficient, and we were unable to identify published literature which evidenced potential efficiencies. There was an additional concern amongst interviewees that hub and spoke may involve handing over control of procurement to a potential competitor and community pharmacies may be hesitant to lose this control under the current remuneration mechanism.

Conclusions and recommendations

Conclusions and recommendations

Based upon our findings we have developed the following conclusions and recommendations with regards to actions that could better support the community pharmacy network and how the network can in turn be enabled to better support NHS England's strategic priorities.

Conclusions	Recommendations
The COVID-19 crisis highlighted the importance of having capacity in the system to deal with unexpected demand, and with pharmacy playing a key role. This role and capacity will likely be required to meet the demands of future unforeseen issues such as a second wave of COVID-19 cases, or preparatory actions such as providing increased vaccinations ahead of winter.	NHS England should understand any contraction in the community pharmacy network limits the health system's overall ability to deal with crises and other spikes in demand such as winter pressures.
Overall funding appears insufficient to maintain the network at its current scale; with fixed funding and inflationary pressures driving c. 75% of the network into deficit by 2024 based on our analysis. Between 28% and 38% of the network is already estimated to be in deficit as of 2019. This may result in insufficient cash to continue trading and a contraction of the network, reducing access to care. Current funding arrangements and economic conditions risk constraining current healthcare service provision and may lead to increasing demand pressures on other healthcare providers. Primary care networks (PCNs), sustainability and transformation partnerships (STPs), integrated care systems (ICSs), general practice clinics and hospital emergency departments would be left to manage the consequences should a significant proportion of pharmacies exit the network.	NHS England should consider the current funding quantum insufficient to sustain the network. Without intervention from NHS England, only the financially strongest pharmacies will survive – limiting access to essential health services in unprofitable areas. Policy makers should put in place public interest focused safeguards against the English community pharmacy network collapsing as an unintended consequence of short-term cost saving.
Increasing the volume and accessibility of services community pharmacy provides are key aims of NHS England in better supporting other parts of the planned and urgent care systems, but low prices and mismatched incentives are a barrier to investing in these.	NHS England should set prices and funding at a level that supports stated strategic priorities and puts the right incentives in the system. For example, prices based on a fully loaded cost with reasonable certainty over future funding. This would help to incentivise investment in capacity and support pharmacies to sustainably offer services.
The process of commissioning local services is seen by the network as onerous and a barrier to providing services, while pricing methodologies for nationally commissioned services are inconsistent with those utilised in other parts of the health system and other regulated industries. The absence of independent financial regulation places the performance and sustainability of the network at risk, especially given NHS England's near-monopsonist status.	Department of Health and Social Care and NHS England should consider either adopting the principles the government has set out regarding good economic regulation with regards to the community pharmacy network, or establish an independent financial regulator for the system. Good (independent) financial regulation that mitigates the risks of a monopsonistic purchaser could be an important enabler of financial and clinical sustainability for the NHS.

Appendices

References

[1] Annual report and accounts 2018–19. Department of Health and Social Care. 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832765/dhsc-annual-report-and-accounts-2018-to-2019.pdf of Health. 2014 (Online). Available at: https://www.gov.uk/government/publications/nhs-reference-costs-2013-to-2014

[2] The NHS long term plan. NHS. 2019. https://www.longtermplan.nhs.uk/

[3] The NHS Long-Term Plan Explained. The King's Fund. Charles, A., Ewbank, L., Mckenna, H. and Wenzel, L., 2020. [online] Available at: https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained#implementation. [Accessed 3 July 2020].

[4] Community Pharmacy Funding. Briefing Paper Number 07811. 2016. [online] House of Commons, pp.3–23. Available at: https://researchbriefings.files.parliament.uk/documents/CBP-7811/CBP-7811.pdf. [Accessed 8 July 2020].

[5] Community Pharmacy In 2016/17 And Beyond: Final Package. Department of Health, 2016. [online] London: Department of Health, pp.3–18. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf [online] [Accessed 10 July 2020].

[6] The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan. NHS England and NHS Improvement (NHSE&I). 2019.Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819601/cpcf-2019-to-2024.pdf.[Accessed 3 July 2020].

[7] Services and commissioning. Pharmaceutical Services Negotiating Committee (PSNC). Available at: https://psnc.org.uk/services-commissioning/. [online] [accessed 3 July 2020].

[8] 'STPs and ICS'. Pharmaceutical Services Negotiating Committee (PSNC). Available at: https://psnc.org.uk/the-healthcare-landscape/sustainability-and-transformation-plans/[online] [accessed 3 July 2020].

[9] Integrated Care Systems. BMA. 2019. Available at: https://www.bma.org.uk/media/1978/bma-integrated-care-systems-briefing-jan-19.pdf. [online] [Accessed 6 July 2020].

[10] Are pharmacy-based minor ailment schemes a substitute for other service providers?: A systematic review. Paudyal, V., Watson, M.C., Sach, T., Porteous, T., Bond, C.M., Wright, D.J., Cleland, J., Barton, G. and Holland, R., 2013. British Journal of General Practice, 63(612), pp.e472-e481.

[11] Identification of patients attending accident and emergency who may be suitable for treatment by a pharmacist. Bednall, R., McRobbie, D., Duncan, J. and Williams, D., 2003. Family Practice, 20(1), pp.54–57.

[12] Pharmacy first-liberating capacity. Deenah, M., and Gogna, N. (2015).. Online report: NHS England.

[13] A cohort study of influences, health outcomes and costs of patients' health-seeking behaviour for minor ailments from primary and emergency care settings. Watson, M.C., Ferguson, J., Barton, G.R., Maskrey, V., Blyth, A., Paudyal, V., Bond, C.M., Holland, R., Porteous, T., Sach, T.H. and Wright, D., 2015. BMJ open, 5(2).

[14] The campaign for real self care. The Proprietary Association of Great Britain. 2010. Available at: http://www.pagb.co.uk/publications/annualreview.html [online] [accessed 12 June 2020].

[15] New transfer of care initiative of electronic referral from hospital to community pharmacy in England: a formative service evaluation. Nazar, H., Brice, S., Akhter, N., Kasim, A., Gunning, A., Slight, S.P. and Watson, N.W., 2016. BMJ open, 6(10).

[16] Access to emergency hormonal contraception from community pharmacies and family planning clinics. Lewington, G. and Marshall, K., 2006. British journal of clinical pharmacology, 61(5), pp. 605–608.

[17] Accessing emergency contraception pills from pharmacies: the experience of young women in London. Turnbull, G., Scott, R.H., Mann, S. and Wellings, K., 2020. BMJ Sexual and Reproductive Health.

[18] Oral health promotion in the community pharmacy: an evaluation of a pilot oral health promotion intervention. Sturrock, A., Cussons, H., Jones, C., Woodcock, C. and Bird, L., 2017. British dental journal, 223(7), p.521.

[19] The role of community pharmacists in supporting self-management in patients with psoriasis. Tucker, R. and Stewart, D., 2017. International journal of pharmacy practice, 25(2), pp.140–146.

[20] Self-care support of long-term conditions and community pharmacy. Ogunbayo, O.J., 2015. The University of Manchester (United Kingdom).

[21] Utilization of a Community Pharmacy-Based Service for the Treatment of Uncomplicated Urinary Tract Infections in Scotland. Borchardt, R., 2020.

[22] Cost-effectiveness of pharmacist care for managing hypertension in Canada. Marra, C., Johnston, K., Santschi, V. and Tsuyuki, R.T., 2017. Canadian Pharmacists Journal/Revue des Pharmaciens du Canada, 150(3), pp.184–197.

References (cont'd)

[23] Benefits Of Pharmacist Care In Hypertension In Canada. Canadian Pharmacists Association. 2017. [online] Available at: https://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/Benefits_of_Pharmacist_Care_in_Hypertension_EN.pdf [Accessed 16 June 2020].

[24] netCare, a new collaborative primary healthcare service based in Swiss community pharmacies. Erni, P., von Overbeck, J., Reich, O. and Ruggli, M., 2016 Research in Social and Administrative Pharmacy, 12(4), pp.622–626.

[25] 'Contract and Funding Webinar Series'. NPA. 2019. [online] Available at: https://www.npa.co.uk/FundingWebinars [Accessed 8 July 2020].

[26] Pharmaceutical Services Negotiating Committee (PSNC). Advanced Service Payments. Available at: https://psnc.org.uk/funding-and-statistics/funding-distribution/advanced-service-payments/(accessed 3 July 2020).

[27] NHS England: Missed GP Appointments Costing NHS millions. NHS England. 2019. [online] Available at: https://www.england.nhs.uk/2019/01/missed-gp-appointments-costing-nhs-millions/#:~:text=Each%20appointment%20costs%20an%20average,224%2C%20640%20cataract%20operations(Online) [Accessed 7 July 2020].

[28] Unit Costs of Health and Social Care. Personal Social Services Research Unit. 2013; NHS Reference Costs 2013 to 2014. Department of Health. 2014 (Online). Available at: https://www.gov.uk/government/publications/nhs-reference-costs-2013-to-2014

[29] 'National Tariff Payment System'. NHS Improvement. 2019. [online] Available at: <https://improvement.nhs.uk/resources/national-tariff/> [Accessed 13 July 2020].

[30] 'Archived Reference Costs'. NHS Improvement. 2020. [online] Available at: <https://improvement.nhs.uk/resources/reference-costs/> [Accessed 13 July 2020].

[31] Principles For Economic Regulation. Department for Business Innovation and Skills. 2011. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/31623/11-795-principles-for-economic-regulation.pdf [Accessed 7 July 2020].

[32] 'Airport Charges For 2020 Consultation Document'. Heathrow Airport Limited. 2019. [online] Available at: https://www.heathrow.com/content/dam/heathrow/web/common/documents/company/doing-business-with-heathrow/flights-condition-of-use/consultation-documents/Airport-Charges%20Consultation-Document-Final.pdf [Accessed 13 July 2020].

[33] 'Airport Charges And Passenger Volumes'. Heathrow Airport. [online] Available at: https://www.heathrow.com/company/about-heathrow/economic-regulation/airport-charges-and-passenger-volumes [Accessed 13 July 2020].

[34] 'Airport Charges Regulations.' Civil Aviation Authority. [online] Available at: https://www.caa.co.uk/Commercial-industry/Airports/Economic-regulation/Competition-policy/Airport-charges-regulations/[Accessed 13 July 2020].

[35] Promoting Competition And Investment In Fibre Networks: BT Regulatory Financial Reporting. Ofcom. 2020. [online] Available at: https://www.ofcom.org.uk/__data/assets/pdf_file/0025/190726/consultation-bt-regulatory-reporting.pdf. [Accessed 13 July 2020].

[36] Promoting Competition And Investment In Fibre Networks. Ofcom. 2019. [online] Available at: https://www.ofcom.org.uk/__data/assets/pdf_file/0028/158167/promoting-competition-and-investment-fibre-networks-consultation.pdf. [Accessed 13 July 2020].

[37] 'Thames Tideway'. Ofwat. 2017. [online] Available at: https://www.ofwat.gov.uk/regulated-companies/markets/direct-procurement/thames-tideway/[Accessed 13 July 2020].

[38] Ofwat Guidance On Approach To The Economic Regulation Of The Infrastructure Provider For The Thames Tideway Tunnel. Ofwat. 2015. [online] Available at: <https://www.ofwat.gov.uk/wp-content/uploads/2015/10/gud_pro20150824ttteconreg.pdf [Accessed 13 July 2020].

[39] 'How we're Funded'. Network Rail. [online] Available at: <https://www.networkrail.co.uk/who-we-are/how-we-work/how-were-governed-and-managed/how-were-funded/> [Accessed 13 July 2020].

[40] 'Price Controls'. Office of Rail and Road. [online] Available at: <https://orr.gov.uk/rail/economic-regulation/regulation-of-network-rail/price-controls> [Accessed 13 July 2020].

[41] 'Government Funding For The Rail Industry'. Full Fact. 2018. [online] Available at: <https://fullfact.org/economy/government-funding-rail-industry-bbcqt/> [Accessed 13 July 2020].

[42] General Pharmaceutical Services In England 2008/09 – 2018/19 [NS] [PAS]. NHS Digital. 2019. [online] Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/general-pharmaceutical-services/in-2008-09---2018-19-ns> [Accessed 13 July 2020].

[43] 'Registers'. General Pharmaceutical Council.[online] Available at: <https://www.pharmacyregulation.org/registers> [Accessed 13 July 2020].

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