Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The Company Chemists' Association (CCA) is the trade association for multiple pharmacy operators across England, Scotland and Wales. The CCA's membership includes ASDA, Boots, Morrisons, Pharmacy2U, Rowlands Pharmacy, Superdrug, Tesco, and Well. Between them our members own and operate almost 4,000 pharmacies across Great Britain.

We welcome the opportunity to submit a response to the Government's 10-Year Health Plan for England. We have been encouraged to see the Government's commitment to the prevention of ill health, as well as the movement of care from hospitals to communities and the better use of technology, which will be a vital enabler to the other ambitions.

Community Pharmacy already plays a crucial role in delivering these ambitions through a wide range of services. There are, however, opportunities to build on these to maximise outcomes for patients and free up capacity for the wider NHS.

Prevention of ill health

- Pharmacists are experienced providers of vaccines. They have delivered over 42 million covid vaccinations to date, and more than 3 million flu vaccinations since September 2024.[1,2] **We would like to see an expansion of pharmacy vaccination programmes**. This is particularly important given recent drops in national levels of vaccine uptake. Pharmacies could easily provide pneumonia, shingles, meningitis, RSV and routine childhood vaccinations across England, increasing overall access, and particularly in the most deprived communities.
- Smoking accounts for around 75,000 deaths annually.[3] These are disproportionately skewed towards disadvantaged groups. **The government should capitalise on the reach of pharmacy in underserved areas and commission a national smoking cessation service**.
- Pharmacies are currently one of the main routes of access to emergency hormonal contraception (EHC). However, there is significant variation in free-at-the-point of access EHC. **We recommend the introduction of a national EHC service.**
- Community pharmacies have excellent reach among local populations, particularly among underserved group and they already play a crucial role in screening. **We would like to see screening services expanded to enable the prevention of more ill health**. This could include,
    - expanded hypertension case finding
    - atrial fibrillation detection
    - diabetes and cholesterol screening
    - cancer screening

Movement of care from hospitals into the community

- In the first 9 months of the Pharmacy First service, pharmacies delivered 1.4 million urgent care patient consultations for conditions which would otherwise have been seen in other parts of the healthcare system. **To build on this success, we strongly recommend an expansion of the existing Pharmacy First service.**
- From 2026 all newly qualified pharmacists will be independent prescribers (IP). There must be opportunities for pharmacists to use these skills **and we would like to see the introduction of services in community pharmacies that fully utilise independent prescribing**. For example:
    - Long term condition management e.g. initiation and management of uncomplicated hypertension or respiratory disease care.
    - Deprescribing of routine medicines of medicines that are no longer appropriate for patients, of those which have no clinical value.".
- **A movement towards diagnostics and treatment within pharmacies**, through which pharmacies are enabled to be a crucial part of the multi-disciplinary healthcare system and able to provide complete episodes of care.
- The creation of greater capacity in community pharmacies which will allow more care to be moved into the pharmacy network. This will be enabled through both **pharmacy technician-led and automated**, **sustainable supply of medicines**.

Movement from analogue to digital

- The potential for delivering more care from community pharmacies is hampered by incomplete access to patient information, and a digital infrastructure that is isolated from other NHS providers. **Community pharmacy systems must be integrated with the NHS** allowing:
    - interoperability between NHS providers
    - standardised referrals in and out of pharmacies
    - integrated booking systems adhering to Booking and Referral Standards (BaRS)
- Many NHS processes are merely digitised versions of original paper-based solutions. **There needs to be a review of regulation and operations, to design digital-first.** Examples include real-time claiming of and payment for activity undertaken, better public reporting of activity, and digitisation of prescription tokens. In time, this will support primary care becoming paperless – in line with NHS Net Zero ambitions.
- Independent Prescribing is the most significant change to pharmacy practice in decades. To allow commissioners to take advantage of this opportunity **community pharmacies need the tools to support both prescribing itself, and the associated governance**,
- The electronic prescription service (EPS) is in effect a paper-based system which has been digitised. To support greater automation and a future AI enabled dispensing service there is a need to review EPS. This includes allowing single item prescribing by default, greater patient and pharmacy control of prescription periods of treatment, a move away from the concept of a prescription 'form' and remove the need to print hard copies of any electronic prescription tokens to send to the NHS BSA.

Whilst there are opportunities to expand pharmacy services to patients, the Government must first recognise the debilitating impact of the ongoing pharmacy funding crisis, which has left the pharmacy network on the brink of collapse. Unless this is addressed, as a matter of urgency, not only are new services untenable, but the network's ability to deliver the most basic of existing services, is dangerously at risk.

In 2016/17 pharmacy funding was cut by £200m. It was cut again in 2017/18 and has remained flat ever since. Whilst the current funding arrangements allow pharmacies to retain £800m of margin in profit, it has remained at that level since 2014/15, except for 2022/23 and 2023/24 when it was increased by a non-recurrent £100m across the two years. At the same time, the number of prescription items dispensed, and the cost of medicine has risen substantially.

NHS BSA data shows that in 2023/24, for example, community pharmacies dispensed over 1.1bn prescription items.[4] This is almost 100 million (10%) more than in 2017/18. During the same period, the number of interactions between pharmacists and patients through nationally commissioned clinical services increased by 120% reaching over 12.4m in 2023/24.[5] In short this means pharmacies are doing far more for much less.

In 2023 CCA uncovered an annual funding shortfall of more than £67,000 per pharmacy in England when compared to 2015/16.[6] We estimate that in the intervening period, this has since risen to more than £100,000 per pharmacy in England.

Underfunding has already led to an extremely worrying rate of closures. The Government's own figures show that between 31 March 2017 and 30 September 2024, there was a net loss of 1,250 pharmacies. Without urgent action, we are concerned that this will only continue and patients' access to healthcare will be further compromised.

CCA analysis also shows that closures are disproportionately skewed towards more deprived communities, with 35% of closures occurring in the 20% most deprived communities.[7] This is particularly concerning considering that, in contrast to other parts of the healthcare system, community pharmacy has better reach within deprived areas. This enhanced access is known as the positive pharmacy care law.

As an immediate priority the Government must address the current funding shortfall as part of the 10-Year Health Plan.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Community Pharmacy already plays a key role to play in moving care from hospitals to community, not least through the Discharge Medicine Service (DMS) and Pharmacy First, which delivers urgent care in the community. Whilst there are clear opportunities to expand access, though the expansion of existing services and the introduction of independent prescribing services, there are numerous barriers which must be addressed.

Funding

First and foremost, funding issues must be addressed. As outlined in our response to question one, community pharmacy is facing a significant funding crisis. Whilst businesses want to invest in innovative services and practices they are severely limited by the lack of funding.

This not only hinders their ability to deliver new services, but it undermines their ability to deliver essential services. The Discharge Medicine Service (DMS), for example, is a highly effective and cost-effective intervention. Evidence shows that for every ten DMS consultations, there is one avoided hospital admission. DMS relies on hospital referrals and is extremely variable across the country. There is a 324-fold difference between the highest and lowest performing ICS so far in 2024. Hospital engagement and capacity is limiting patient benefit. DMS should not rely solely on hospital referrals and pharmacies should be able to identify patients who would benefit from this intervention.

However, even if hospitals were to fully engage with the service – funding constrictions mean this additional workload would risk pharmacy viability. At present the potential of the service is limited by a lack of investment and the resulting paucity of resource.

To move more care from hospitals to communities, not only do existing services need to be sustained, but more services need to be commissioned. To do this, businesses must be in a healthy place, having the confidence and capacity to plan-ahead and invest in essentials such as equipment and consultation rooms, digital advancements and the workforce.

Regulatory

At present pharmacists spend most of their time dispensing medicines. This means that there is little time left for the delivery of more innovative clinical services which would support the transfer of care from hospitals to communities. This is despite the fact that repeat medication now makes up approximately 77% of items dispensed in primary care,[8] which require limited direct clinical intervention.

In reality, the vast majority of dispensing tasks undertaken could be safely undertaken by another member of the pharmacy team or by technology. This is, however, also hindered by regulatory barriers.

To enable the movement of clinical care from hospitals to the community, regulatory change is necessary. The implementation of supervision changes, which have been delayed, will enable technician-led dispensing and make the best use of the skill-mix within the pharmacy team. It would also provide a clear role for technicians in the community and free up pharmacist time to deliver clinical services. Pharmacists should focus their involvement in dispensing on interventions with the greatest clinical value (e.g. discussing medicines with patients or querying prescriptions with prescribers) but should not need to be involved in routine operational tasks.

Workforce

Years of harsh efficiency savings have severely reduced the capacity of the community pharmacy workforce. Despite the NHS Workforce Plan setting out ambitions for workforce growth, the Community Pharmacy Workforce Survey shows that the number of Full Time Equivalent (FTE) pharmacists working in community settings is decreasing. This has been coupled with a significant decline in the number of technicians working in community practice.

The workforce crisis has been exasperated by the continued recruitment of pharmacy professionals from community pharmacies and into Primary Care Networks. NHS data shows that since March 2019, over 8,000 FTE pharmacists and 2,765 technicians have been recruited into primary care.[9] The majority of these have come directly from community pharmacies. The Government have met their target for additional General Practice staff early. The NHS should halt recruitment under the ARRS scheme until they can set out how it can be appropriately managed without further impacting community pharmacy.

As well as ensuring appropriate workforce capacity, it is essential that colleagues have the confidence and capability to deliver in line their new roles.

Whilst changes to supervision legislation will enable pharmacy technicians to play a greater role in dispensing, they must be supported with training to ensure the necessary skills and confidence.

Likewise, there must be concerted efforts to upskill the existing pharmacist workforce. Whilst all newly qualified pharmacists will have independent prescribing qualifications from 2026, in September 2023 the Community Pharmacy Workforce Survey found that only 8% of community pharmacists were independent prescribers.[10] Of these only around 10% were currently prescribing. If enough care is to be transferred to the community to support improvements in the wider healthcare system, efforts to train the entire workforce will be essential.

Digital

If pharmacies are going to play a central role in the movement of care from hospitals, there must be mechanisms to:

- Direct patients to the appropriate part of the healthcare system: At present there is confusion about which parts of the NHS patients should attend. Patients require clarity, the NHS app would be a good starting point to support this.
- Communicate seamlessly between healthcare settings: This includes the ability for pharmacist to access records, update notes, and notify the patients GP of interventions made. This includes the ability to view and request testing, such as phlebotomy. Pharmacy teams should also be able to electronically refer patients directly to the most appropriate location, without going through the 'bottleneck' of a stretched general practice. Similarly, all parts of the NHS should be able to send referrals to community pharmacy for care, in line with new referral standards.

At present access to patient records in pharmacy is disjointed. Whilst the introduction of GP Connect offers a helpful first step forward, to be effective it requires buy-in from all partners, which is currently often lacking. Integration can only happen if both parties wish to integrate.

A single patient record would transform the transfer of care. This must be a national system; local systems would exacerbate a fragmented system rather than offering benefits. We are concerned that different systems across ICBs would be unworkable given both healthcare providers and patients work and access care across ICB boundaries.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Making better use of technology is essential within the healthcare space. To make best use of technology there are barriers that need to be addressed.

Alignment of approach

At present digital services are disjointed and inconsistent. ICBs, for example, often take different approaches, and use different systems and digital standards which do not align. It is extremely difficult for community pharmacies, who provide care across boundaries, to engage with 42 different systems' services which may or may not talk to each other and which may take 42 different approaches to data protection or clinical governance.

This is one example, but there are numerous, including a variety of referral systems, multiple different local healthcare records and uptake of 'GP Connect'. If healthcare is going to make better use of technology, it must agree a common and standardised approach in which different healthcare settings can communicate easily. National strategy has been clear, with the introduction of the National Booking System, Booking and Referral Standards, and improvements to the NHS App setting a clear direction of travel. National projects support innovation in care and digital technology. Unfortunately, local implementation of national strategy is causing variation and risking the NHS' digital ambitions.

Fragmented governance and data protection

GP Connect is one example of integration between community pharmacy and another part of the NHS. It is transforming care, offering new avenues of service delivery previously unavailable to pharmacy teams. Unfortunately, general practices are not universally engaging with this process for a variety of reasons, from finance to a different understanding of data legislation and responsibility. Similarly, with local ICS digital projects, different understanding of respective governance processes between pharmacy providers and NHS bodies acts as a barrier to innovation. There is a need to create a framework for data sharing, that accounts for varying ways of working across NHS providers. This will reduce bureaucracy, encourage sharing of data, and turbo charge innovation. Ultimately, this is a step towards a single patient record held across different providers and owned and controlled by the patient.

Funding

As previously discussed, companies require confidence to plan and invest in their businesses and the future. At present pharmacies are compromised by extreme funding shortages, coupled with unnecessary regulatory barriers.

Despite best efforts, the confidence to invest is currently lacking. This was not always the case. Many pharmacy businesses have, for example, invested heavily in automation. They are, however, hampered by barriers which inhibit further spending. For example, whilst workload, and cost have been shifted to automated facilities, there are insufficient opportunities for businesses to earn new money using the workforce capacity released. As a result, businesses are unable to justify further investment in the technology. Similarly, investments in paperless processes are hampered by outdated regulations that require paper copies of prescription tokens.

As well as a lack of funding, the current model of funding for pharmacies often leads to significant irregularities in cashflow. Over delivery of services for the NHS, results in monies being clawed back from elsewhere in the contractual framework anywhere between 6-12 months later. This makes forward planning and investment decisions very difficult.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

The barriers and enablers to preventing ill health largely mirror the barriers and enablers for moving care from hospitals to community settings and making better use of technology. In addition we would like to highlight challenges associated with commissioning and the opportunity that better marketing of community pharmacy would provide to the prevention of ill health.

Commissioning

At present, local authorities are responsible for commissioning many aspects of prevention and public health. Whilst we recognise that local authorities understand their local populations, unfortunately commissioning is often disjointed and extremely variable across localities. For patients this leads to post code lotteries where they can access care in one area, but not another. For businesses, it creates added legal, financial and administrative complexities during which they must liaise with multiple partners. ICBs were intended to improve co-ordination between local government and NHS bodies. Whilst there are some early signs of change, this does not address variation across the country.

Local commissioning should address the specific needs of a locality – building on the foundation of a universal offer. The COVID vaccine programme demonstrated the benefit of a clear national understanding, with local initiatives built upon this. To counter these issues, we would like to see a standardised care offer for patients commissioned across the country.

Furthermore, contracts for the provision of local services are often short term. Without sufficient surety of income, is it difficult for providers to make the long-term investment decisions necessary to deliver innovation for patients. This is particularly true for prevention activity where there are few well-established models of care that have been commissioned.

Many commissioning opportunities operate on an 'in-year savings' basis. This fails to recognise the benefits of public health interventions which are realised over a significantly longer period.

Multiyear contracts are critical to allowing providers time to 'bed-in' operating models – especially when population level interventions or behaviour changes are needed. For prevention to be successful commissioners must acknowledge that providers will be unlikely to demonstrate in-year savings. The return on investment will be felt over a longer period – but the benefit to the taxpayer and the population health, are significant.

Health promotion

Community pharmacies are extremely well placed to prevent ill health. PHE analysis notes that their central locations and convenient opening times mean that they are some people's first and only point of contact with a healthcare professional.[11] A recent review also found that people visit their local pharmacy 12 times more frequently than their GP.[12] This is particularly important among disadvantaged groups, who tend to suffer greater levels of preventable ill health. Whilst access to healthcare tends to be more limited where there is greater need (the "inverse care law"[13]) the reverse is true in community pharmacy,[14] where access is higher in areas of greater deprivation.

Despite this, the reach of pharmacies is not currently being optimised. There are opportunities to undertake proactive marketing using pharmacy teams to actively engage the population on mass. Multiple pharmacies are particularly well placed to reach almost all groups through high streets, out of town shopping centres, supermarkets and health centres. CCA members, in particular, have well-known brands that reach outside of healthcare. There is huge untapped potential to shape the health of the nation through large national brands, working to joint outcomes.

As part of this, learnings should be drawn from the covid vaccination programme, which reached the majority of the population within a relatively short time period.

Q5. Specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- **Quick to do, that is in the next year or so**
- **In the middle, that is in the next 2 to 5 years**
- **Long term change, that will take more than 5 years**

Quick to do

- **The government must address urgent funding challenges to ensure the sustainability of the community pharmacy network**. **This must include an uplift to the retained margin for medicines procurement and actions to prevent medicine shortages which cause ever rising costs to the taxpayer**. Without this community pharmacies are severely undermined. Not only does the expansion of clinical services become untenable, but existing access will be further compromised. This is likely to result in even more pharmacy closures.

- As well as funding, an expansion of pharmacy services will require a change to the way in which all pharmacy colleagues operate. This includes a reduction in the amount of time pharmacists spend dispensing. **There are several necessary regulatory changes needed to support this, including legislation to enable:**

- **Supervision changes:** to enable pharmacy technicians to play a greater role in dispensing and the supply of pre-authorised medicines when there isn't a pharmacist present.

- **Hub and spoke:** enabling hub and spoke models across different legal entities. When taken alongside further investment in dispensing, and changes to allow pharmacists to supply +/- 10% of prescribed medicines, this could significantly improve dispensing efficiency.

- **An increasing focus on clinical service delivery must be underpinned by appropriate workforce capacity and capability.** Whilst this should start immediately, we recognise it will be an ongoing policy objective that will take several years to roll out.

- **Capacity: ensuring adequate number of staff**
  - Recruitment into Primary Care Networks: Funded through ARRS monies, this has had an extremely detrimental impact on retention on pharmacists and pharmacy technicians in the community. The NHS should halt recruitment under the ARRS scheme until they can set out how it can be appropriately managed without further impacting community pharmacy.

- **Capability: upskilling of the entire of the workforce**.
  - Undergraduate pharmacy students: The CCA welcomed changes to the undergraduate pharmacy degree, which will enable pharmacists to play a great role in the delivery of clinical care. There are, however, several issues which need to be addressed. At present there are insufficient number of Designated Prescribing Practitioners (DPPs) supervisors to support prescribing elements of the degree. Furthermore, the clinical tariff which funds clinical placements is extremely low, meaning many placement providers are struggling to engage fully. The Community Pharmacy Workforce Development Group has set out several recommendations as to how these issues can be addressed.
  - Existing pharmacists: The vast majority of existing pharmacists do not have prescribing qualifications. To avoid the development of a two-tier workforce and ensure the potential of IP services are met, NHSE must invest in further training as a matter of urgency. There must then be commissioned IP services to warrant the training time undertaken by individual professionals.
  - Pharmacy technicians: Whilst changes to supervision legislation will enable technicians to play a greater role in dispensing, this must be underpinned by sufficient training to ensure the necessary levels of competence and confidence.
  - All: At present learning and development opportunities within pharmacies are often underutilised because of a lack of protected learning time or backfill for staff. This makes it extremely difficult for businesses, who are often already working at capacity, to release colleagues to participate in training.

These changes will facilitate increased clinical services within the sector, for which there are numerous opportunities for expansion.

- **The government should build on the success of the pharmacy first service, expanding it to include a range of other conditions.** This would better mirror similar services across the devolved nations and could include lower back pain, respiratory tract infections, conjunctivitis, and skin conditions such as acne, eczema and psoriasis.

- **NHS England should commission community pharmacies to deliver a wider range of NHS vaccines including pneumonia, shingles, meningitis, RSV and routine childhood vaccinations.** The most recent data shows a national drop in vaccine uptake. The pharmacy sector has shown time and time again that it is well placed to reach underserved groups and

to those who need it the most. CCA analysis, for example, shows increased access to Covid vaccinations in pharmacies for groups more likely to show vaccine hesitancy.[15] The government must now build upon this.

- **An expansion of the vaccination services must take account of the skills of the wider pharmacy team**. Whilst pharmacy technicians are already able to deliver vaccinations under Patient Group Directions, they are often excluded through service specifications which require a vaccination trained pharmacist to be present. This undermines the role of pharmacy technicians and inhibits increases in pharmacy capacity. We urge NHS England to rectify this without delay.

- **A national Emergency Hormonal Contraception (EHC) service should be introduced. This could be tagged onto the existing contraception service with almost immediate effect.** Pharmacies are currently one of the main routes of access to EHC. However, at present there is significant variation in free-at-the-point of access EHC (which is only commissioned from about half of pharmacies in England). This is particularly important, given variability in access comes in the context of significant (and growing) unmet need:
    - 45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence.[16]
    - OHID data shows that:
        - In 2021 the highest number of abortions were conducted in England and Wales, since the 1967 Abortion Act was introduced.
        - Rates of abortion in the most deprived areas are more than double those in the least deprived areas.[17]

- **An expanded community pharmacy smoking cessation services should be commissioned nationally without delay.** Whilst national NHS smoking cessation support is available in pharmacies, provision is extremely limited, requiring inpatients to be referred via hospitals. Given smoking in England accounts for approximately 75,000 deaths a year[3] and costs the NHS £2.6bn annually, it is extremely concerning that in 2023/24 there were only around 6,000 smoking cessation consultations via the national service.[18] Whilst local services are available in many areas, commissioning is disjointed and extremely variable. A broader pharmacy service would not only make use of the many pharmacy colleagues who are already training to deliver smoking cessation support, but it would address one of the key national drivers of health inequalities.

- **Expanded access to screening services should be made available through community pharmacy**. This would capitalise on the reach of community pharmacies in local populations, particularly among underserved group.
    - Hypertension: Community pharmacies currently deliver a nationally commissioned NHS hypertension case-finding service. They provided over 1.7m blood pressure checks last year.[18] Given that CVD is one of the leading causes of premature death, there is an urgent need to scale-up. The CCA estimates that pharmacies could screen up to 5 million people a year.
    - Cholesterol and diabetes prevention: Community pharmacies could deliver cholesterol and Type 2 Diabetes screening, both of which can be identified using a finger prick blood test and are already being offered as private services by many community pharmacies.
    - Atrial Fibrillation: Already piloted in some areas using a portable device, an AF screening service would help identify those with undetected AF. Given that those with undiagnosed AF have a 35% chance of eventually suffering from an AF-related stroke, this would be an important mechanism to prevent ill health.

Mid term

- **As a next step to the Pharmacy First service, more treatment options should be added to the Pharmacy First service**. Pharmacy First is a natural starting point for independent prescribing within pharmacy. Not only would it give pharmacists autonomy to prescribe the most appropriate treatment option to patients, but it would increase the reach and impact of the service.

- **In the midterm we would also like to see IP expanded to include the ongoing management of treatment and secondary prevention.** This would align well with the existing hypertension service and could include initiation of treatment.

- **As prescribing is embedded in community pharmacy, this must be recognised as a part of the wider healthcare multi- disciplinary team.** There will need to be changes to enable effective working including:
    - Solutions to address the current challenges of sharing employees across primary care employers.
    - Shared recognition of clinical governance processes across different sectors. Different providers need confidence in, and awareness of interventions made by other healthcare professionals.
    - A single patient record is needed that allows all healthcare providers, regardless of setting or employer, to have appropriate access to. Any interventions made should be added to this record, preventing patients from having to explain their care, whilst improving patient safety.

- **As IP is embedded, the roles of other staff members will also need to develop.** Consideration should be given as how the role of pharmacy technicians can expanded, for example, through their inclusion on a wider range of PGDs and an expanded role within the dispensary.

- **Regulatory change to empower patients to manage their own health, including both acute and long-term conditions, will also be important**. This should include the exploration of therapeutic areas and specific drugs appropriate for switching from Prescription-only to Pharmacy-only.

Long term

- **In the long-term, independent prescribing must evolve to include a full independent prescribing service.** This could involve the management of treatment for long terms conditions, menopause support or deprescribing.

- **As pharmacy services develop and pharmacists deliver more complex care, community will need access to enhanced diagnostics.** As well as screening, this includes pathways to access to pathology as well as phlebotomy services and more advanced point of care testing.

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