

**APPG**



**All-Party Pharmacy Group**

**REPORT OF THE INQUIRY  
INTO PRIMARY AND  
COMMUNITY CARE:  
HOW CAN SERVICE  
IMPROVEMENTS BE  
ACHIEVED AND WHERE  
DOES PHARMACY FIT?**

**Chair, The Rt Hon Sir Kevin Barron MP**

**Vice Chair, Oliver Colvile MP**

**Vice Chair, Baroness Cumberlege CBE DL**

**Treasurer, Paula Sherriff MP**

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# 1. INTRODUCTION

- 1.1. In October 2015 the All-Party Pharmacy Group (APPG) launched an inquiry into primary and community care. The inquiry sought to understand the greater role that pharmacy could, and should, be playing in the context of the Five Year Forward View and its focus on prevention. The Group is particularly interested in population health, given the duty in the Health and Social Care Act 2012 for the Secretary of State to protect or improve public health.
- 1.2. The inquiry gathered both oral and written evidence from a broad range of stakeholders, including commissioners, health professionals, policymakers and patient groups, to hear examples of where pharmacists were already excelling at making the NHS more efficient, and also environments in which pharmacy should be playing a greater role.
- 1.3. From the evidence received, it is clear that pharmacy should be doing more to ease the pressures faced by the NHS. Unhealthy lifestyles are perhaps the biggest threat to the nation's health, and the only sustainable response is an approach based on population health. Specifically, much of the evidence pointed towards using the clinical skills of pharmacists, rather than simply dispensing medicines, in order to help people improve their lifestyle and stay healthy, avoiding costly ill-health.
- 1.4. The proposals announced in [a letter](#) dated 17 December 2015 from the Department of Health have had a direct and major bearing on this inquiry. We urge the Department of Health to consider the evidence and recommendations set out in this paper, as we strongly believe that it is only by using the skills of the pharmacy sector that we can achieve optimum efficiency in the NHS and balance the £30bn funding gap estimated to materialise by 2020/2021.

# 2. SUMMARY OF EVIDENCE

- 2.1. The Group is grateful to all the organisations and individuals that gave evidence to the inquiry, in writing and at our evidence sessions. We heard from a variety of stakeholders and are especially grateful to NHS England and the Department of Health for their open and transparent engagement with our inquiry.
- 2.2. A summary of each evidence session is attached to this report. Written evidence was mostly submitted to the inquiry before the Government announced its proposed reforms in December 2015, oral evidence was mostly taken afterwards.

- 2.3. We heard that pharmacy is continuing to develop in the direction long championed by the Officers of the Group, the Government and community pharmacy leaders. We believe that a clinically focused, accessible network of pharmacies dispensing medicines in local communities creates opportunities for a host of health interventions that can keep people well and help them to manage health conditions, staying out of hospital and away from the GP surgery. In doing so, community pharmacies become the frontline of an NHS focused on population health.
- 2.4. Realising this vision requires a major cultural change, in community pharmacy and in the NHS. Progress has not been as fast as the Group would like, and community pharmacy continues to be a source of untapped potential. Evidence from Dr Denise Taylor at the University of Bath supported our conclusions on the funding model and on the balance of skills in community pharmacy. She said, ‘The focus on payments per prescription item places the emphasis on prescription generation. In community pharmacy it also means that the pharmacist is almost always behind the dispensary bench, checking and dispensing prescriptions. The pharmacist is a highly trained clinician and should be front of counter consulting with patients’.
- 2.5. We saw excellent examples of innovation and integration. In Dudley, for example, a Pharmaceutical Public Health Team based at the Borough Council helps to coordinate community pharmacy services across secondary care, primary care, care inside community pharmacies and self-care. In West Yorkshire, a Pharmacy First service is commissioned to provide the local population with rapid access to a pharmacist who can give self-care advice on a range of minor ailments releasing capacity in general practice and providing an appropriate alternative to the use of general practice or other health care environment. The evidence we heard suggests that examples like these are not replicated throughout the country. Commissioning and service provision continues to be patchy. Patients and the public, as well as members of the Group, highlighted the value of personal relationships with individual pharmacists, and preferred models of pharmacy that ensured continuity, where the same pharmacist serves the same community over time.
- 2.6. Evidence from the South East London Area Prescribing Committee, Pharmacy and Public Health Forum and South Devon and Torbay CCG usefully highlighted barriers to integration in primary care as it is now, notwithstanding the Government’s proposals. Poor inter-professional relationships are a major barrier to effective inter-professional working and therefore to integration in primary care. Professionals, specifically pharmacists and GPs need

to work harder to understand and trust each other. Consistency of behaviour on both sides, when dealing with prescription queries or referrals, for example, is an important aspect of this. Pharmacists also need full read/write access to patient records. There are the challenges and barriers to achieving this, but it is an important driver of integration and joined-up care.

- 2.7. Integration in primary care extends beyond pharmacists working with GPs, however. The Group heard evidence on the role of pharmacy in care homes, and was impressed by the Government's plans in this area. Representatives of patients and the public emphasised the need for good governance to safeguard choice and autonomy for care home residents. Witnesses welcomed the prospect of residents having access to pharmacists' expertise and the ability to build a relationship with a dedicated professional.
- 2.8. We heard a great deal of concern from representatives of patients and the public, as well as community pharmacy, about the potential for pharmacies to close as a result of the proposed funding changes. A 2015 survey by Healthwatch England showed that access to primary care is the number one health service concern for the public.
- 2.9. We heard particular concerns about closures in deprived and rural areas. We were impressed by evidence of community pharmacy's impact addressing population health in deprived communities contained in Pharmacy Voice's Dispensing Health report. The Minister was clear that the Government does not have an agenda to close pharmacies, and said that the proposed Access Fund will mitigate the impact on rural areas and deprived areas. He has told MPs that the Government cannot predict how, when and where the funding changes will affect community pharmacies. We heard that uncertainty about the impact of funding changes could affect pharmacies' access to finance and could already be preventing investment in services.

### 3. COMMENTARY

- 3.1. The Group continues to believe that pharmacy in England can do more to improve health outcomes and promote population health. Pharmacies should be the accessible, free source of health services, home to population health champions and expert advice on how to get the most from medicines. This is consistent with recent advice from the Department of Health and NHS England, suggesting that members of the public visit the pharmacy first for advice and health services.

- 3.2. The Group is concerned by the pace of change in community pharmacy. New services such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS) have been a modest but important success story. We have heard evidence that these services, introduced over the past decade, are helpful interventions and provide good value for money for the NHS. The Group believes that these services represent a small step towards the future of community pharmacy, using the platform of dispensing to provide clinical services. Dispensing remains the core of the pharmacy service, and requires both care and skill, but it also provides an opportunity for a host of other health interventions, particularly focusing on population health. We are not making the most of this opportunity. Most pharmacists spend a tiny proportion of their time providing these additional interventions, and a much larger proportion dispensing medicines or supervising staff to do so.
- 3.3. To achieve this future, the Group believes that the sector should focus on technology, professionalism and integration. A strategy for developing community pharmacy should cover each of these strands, ensuring that community pharmacy meets the needs of patients, is provided efficiently, and reduces pressures on the rest of the NHS, particularly General Practice and emergency care.
- 3.4. The All-Party Pharmacy Group has long held the view that community pharmacy funding needs to change. Pharmacists should be incentivised to develop their clinical capabilities for the benefit of patients and the NHS. This means that pharmacy funding should increasingly incentivise new clinical services, building on the platform of dispensing medicines. The proposals as announced in December 2015 do the opposite by halting the commissioning of new clinical services and moving towards a 'single activity fee' for dispensing. This emphasises dispensing over clinical services, marking a reversal of the policy of successive Governments dating back to at least 2005.
- 3.5. In May 2016, NHS England told a meeting of pharmacy stakeholders that it has commissioned a review of the value of existing clinical services. Little information on the review was available to the All Party Group beyond reports in the specialist press and terms of reference taken from slides presented at the meeting.<sup>1</sup> As such the Group is unable to comment on the opportunities and risks posed by the review, beyond noting that the review

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<sup>1</sup> <http://psnc.org.uk/wp-content/uploads/2016/04/160428-Consultation-event-Community-pharmacy-in-2016-17-and-beyond-FINAL-REVISED.pdf>

will lead to continued uncertainty for community pharmacy even after the Government announces its intentions following the consultation.

- 3.6. The Government envisages local authorities commissioning pharmacy services when the Department of Health and NHS England centrally decline to do so. Local authorities have not been provided with sufficient funds, and have competing calls on their budgets. We have heard that some local commissioning has been very successful, but it has been patchy and inconsistent, sometimes confusing patients about what is available and where. If pharmacies' viability is threatened by changes to funding, Local Authorities may not have the option to commission services.
- 3.7. The Government is right to note that increased automation could free up time for pharmacists to provide more clinical services like Medicines Use Reviews and the New Medicine Service. Changing the division of labour within pharmacy teams, hiring additional pharmacists or supervising staff in different ways can also free up time for services. We heard contradictory evidence on the potential for 'hub and spoke' systems to create efficiencies in independent pharmacies. The Chief Pharmaceutical Officer highlighted the potential for automation to improve safety, while Pharmacy Voice and the National Pharmacy Association were sceptical about its ability to save money and wary of the potential for automated systems to replace human interactions. We are grateful to the Chief Pharmaceutical Officer for clarifying his evidence on the safety of automated systems. The clarification is available [here](#), and an analysis of the evidence from the Pharmaceutical Services Negotiating Committee is available [here](#).
- 3.8. We have heard about the risk that the development of new services adds to workplace pressures for pharmacy teams, particularly when linked to targets and commercial incentives. Pharmacy teams have a professional duty to their patients, and this must always trump other concerns. Community pharmacy needs a culture that supports professionals to discharge their duties in the best interests of patients at all times. Responsibility for this rests with employers, individual professionals, the professional leadership bodies and the regulator.
- 3.9. The Group supports the Government's drive to house pharmacists in GP surgeries, in line with NHS England's Forward View for General Practice. This has the potential to build additional capacity in General Practice. Pharmacists' skills can help to triage patients, optimise prescribing and help patients to get the most from their medicines. This capacity building initiative should not, however, come at the expense of capacity releasing

mechanisms, specifically patients' ability to visit a community pharmacy instead of the GP surgery. The physical community pharmacy estate is an important asset to primary care teams across the country, reducing GP appointments and preventing hospital attendances. It should not be undermined and locating pharmacists in GP surgeries is not an alternative to service provision by community pharmacies.

- 3.10. There is a risk that members of the public become confused by mixed messages. NHS campaigns have instructed people to choose pharmacy first rather than going to their GP or to A&E. With GP surgeries taking on pharmacists and pharmacies potentially closing, members of the public may be discouraged from visiting pharmacies. People may be further confused if locally commissioned services mean that levels of service provision in community pharmacies differs from place to place.
- 3.11. We did not see evidence in support of any specific number of pharmacies. The current shape of the network has developed partly from local needs assessments, partly from market forces. Ultimately, the number of pharmacies required will be determined by the kind of service the NHS requires from pharmacy. If the NHS only wants pharmacies to supply medicines to patients, a smaller number may be appropriate. If the NHS wants a clinically-driven service based on face-to-face interactions, in our view a larger number of pharmacies is required.

## RECOMMENDATION 1

**The Government and PSNC must reach a negotiated settlement on the community pharmacy contractual framework.**

- a. Government has long championed the development of community pharmacy. The community pharmacy contractual framework has been agreed between pharmacy and the Government every year since the new contract was introduced in 2005. This spirit of cooperation and shared vision must continue. **An imposed contract would send unhelpful signals to the sector and risks hampering its development.**
- b. PSNC has published a set of counter-proposals and shared them with the Department of Health and NHS England. These proposals aim to make the required savings without reducing services provided by community pharmacies. **We would welcome a view from Government on the viability of these proposals and believe they merit a detailed response.**



## RECOMMENDATION 2

**The future of community pharmacy should be secured by investing in technology, developing professionalism in pharmacy and integrating pharmacy into primary care.**

- a. The Government's proposals rightly include an emphasis on technology, which can increase convenience while reducing costs. Technological innovation tends to be adopted in phases: experimentation, demonstration at scale and dissemination. The Group is concerned that if funding arrangements are based on assumptions for savings from technology, different types of community pharmacies will not have time to refine and adopt the best technological innovations for their setting. This risks unintended consequences. **The Community Pharmacy Contractual Framework should not reflect savings from technological innovations until they have been demonstrated at scale and in different pharmacy settings (i.e. independent pharmacies and multiple pharmacies).**
- b. Given community pharmacy's potential to relive pressures on general practice and emergency medicine, **the Government should work with the Royal Pharmaceutical Society and others to agree a strategy that develops the community pharmacy workforce and creates opportunities for professionals to put their skills to practical use.**
- c. The proposed Integration Fund is advertised as a means of promoting innovative models of pharmacy. **The Group welcomes the Integration Fund, but recommends that strict controls are established, so that it is not used to top up funding shortfalls for existing services.**

## RECOMMENDATION 3

**Community pharmacy must continue to develop clinical services, using the supply of medicines as a platform for health interventions.**

- a. The Group is concerned that negotiations on a National Minor Ailments Service have come to a halt. Local commissioning of minor ailments services is welcome, but risks inconsistency and confusion for patients. **The Government and PSNC should recommence negotiations on a National Minor Ailments Service. Local commissioners should have regard to the nationally negotiated service specification published in September 2005 when negotiating local services.**
- b. The Group welcomes the Government's review of services in the community pharmacy contractual framework, but believes it should be an opportunity to develop new services. **The**

**Government should expand the terms of reference for the review to include an assessment of the potential for new national services.**

- c. The Group believes that community pharmacy funding should incentivise the development of services, using dispensing as a platform for clinical interventions. **The Government should build in an escalator to the Community Pharmacy Contractual Framework, ensuring that the proportion of fees and allowances linked to service delivery rather than dispensing increases every year, while protecting and appropriately compensating the care and skill that goes into the safe supply of medicine.**
- d. Services must be delivered in a manner that does not compromise pharmacists' professional integrity. **The Royal Pharmaceutical Society and General Pharmaceutical Council should continue to work with pharmacists and employers to ensure a culture of professionalism in community pharmacy.**

## RECOMMENDATION 4

**The Government must address concerns about pharmacies closing due to funding cuts**

- a. The Minister told the Group that the Government has no agenda to close pharmacies. This is welcome, but all the stakeholders we heard from after December had concerns, and the Minister has himself stated that pharmacies will close. **The Government must address these concerns by researching the effect the eventual settlement will have on the viability of different models of community pharmacy.**
- b. **The Government must demonstrate that the proposed Access Fund will ensure all communities have adequate provision of community pharmacies.**
- c. **The Government should match-fund a public awareness campaign, encouraging members of the public to use pharmacy first for relevant conditions.**

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# APPENDIX I: ORAL EVIDENCE

## First Evidence Session – 7<sup>th</sup> December 2015

- Dr Howard Stoate, Chair of South East London Prescribing Committee
- Jonathan McShane, Hackney Councillor and Chair of Pharmacy and Public Health
- Forum
- Dr Jo Robert, Clinical Lead for Innovation and Medicines Optimisation at South Devon and Torbay CCG

## Second Evidence Session – 7<sup>th</sup> March 2016

- Sue Sharpe OBE, Chief Executive Officer, Pharmaceutical Services Negotiating Committee (PSNC)
- Sandra Gidley, Chair of English Pharmacy Board, Royal Pharmaceutical Society (RPS)
- Rob Darracott, Chief Executive, Pharmacy Voice

## Third Evidence Session – 16<sup>th</sup> March 2016

- The Rt Hon Alistair Burt MP, Minister of State for Community and Social Care
- Dr Keith Ridge CBE, Chief Pharmaceutical Officer, NHS England

## Fourth Evidence Session – 10<sup>th</sup> May 2016

- Sarah Hutchinson, Policy Advisor, National Voices
- Kayleigh McGrath, Senior Policy and Public Affairs Officer at Carers UK
- Izzi Seccombe, Chair of the LGA's Community and Wellbeing Board

## Evidence Session on 7<sup>th</sup> December 2015

The Rt Hon Sir Kevin Barron MP, Chair of the All-Party Pharmacy Group chaired the meeting and was joined by Oliver Colville, Vice-Chair of the All-Party Pharmacy Group and Paula Sherriff, Treasurer of the All-Party Pharmacy Group.

In the first evidence session, there were three witnesses:

- Dr Howard Stoate, Chair of the South East London Area Prescribing Committee
- Jonathan McShane, Hackney Councillor and Chair of the Pharmacy and Public Health Forum
- Dr Jo Roberts, Clinical Lead for Innovation and Medicines Optimisation at South Devon and Torbay CCG

### Introduction

Sir Kevin started the meeting by welcoming the witnesses and thanking them for taking the time to come and give evidence at the session. He reminded the experts that the point of the inquiry and this session was to get information on how pharmacy could be playing a greater role in the new models of care which have been announced under the Five Year Forward View - which set out a vision of how the NHS needs to change to meet the pressures it is currently facing.

### Inter-professional working

- Howard Stoate argued that there have been improvements regarding the manner in which pharmacists offer services within public health – and one important area was their work with GPs. He argued that one particular success story was their work on the NMS and the MUR and how well they work alongside and support GPs.
- An example Howard gave was that at Bexley CCG, they now hire pharmacists to work directly with GPs – looking at local and national medicine guidelines together. This helps GPs to improve the care of patients by using the expertise pharmacists have with regards to medicines.
  - In certain cases the CCG will undertake a review of patients taking a particular drug and ask the pharmacists to work directly with the patients to create a better regime to take and manage these drugs.
  - It is then the job of the pharmacists to sit down and discuss these changes with the patients directly and help to monitor the patients.
  - While the pharmacists do not have the ability to prescribe the drugs (this must be signed off by GPs) but they can update the patient records.
  - Stoate emphasised that this has significantly eased the burden on GPs' time.
- Jonathan stated that much of the friction between pharmacy and other healthcare professionals he sees is regarding the business element – it's important to remember that GP practices and pharmacies are commercial businesses.
  - One way to counteract this, he said, is to make one setting the norm for services. For example, rather than have flu jabs delivered by both GPs and pharmacists – make it just

- pharmacists. This will limit the friction between the two professionals.
- This will also send out a positive message about what pharmacy can do – and by directing people there, people will start to understand what else pharmacy can do.
  - Dr Jo Roberts told the meeting that within his CCG, they employ pharmacists to work in GP practices and embed them within the surgeries. He stated that this has been incredibly successful and now pharmacists are now considered vital to the work in GP practices. Essentially, they need to work directly with each other, side by side, to respect and appreciate each other's skill sets.

### Commissioning

- Jonathan McShane argued that one of the most significant problems is that there is not national consistency regarding what pharmacists are commissioned to deliver.
- An example of this is the healthy living pharmacy concept. Currently, a pharmacy can only be a healthy living pharmacy if it is commissioned to be one by their local authority. He argued that every pharmacy should be promoting healthy living and sharing positive public health messages.
- Dr Jo Roberts argued that it's vital to co-commission between pharmacists and GP - as it helps healthcare professionals to work together to decipher what patients' needs are – not necessarily what their wants are. He felt that co-commissioning allows a common goal for people to work together.

### Record sharing

- Record sharing was discussed at great length throughout the meeting and it was generally agreed by the officers that it would be extremely beneficial to pharmacy – of which the witnesses broadly agreed.
- It was agreed that it is extremely difficult for healthcare professional to work together in an effective manner when pharmacists do not have read/write access to patient records.
- However, Howard Stoate did point out that it is hard to share patient records – it's been tested before and it's always failed. This normally comes down to public resistance - people don't want their records and information shared with people they don't know.
- It was also agreed that records should be shared with those who are providing long term care for the elderly in places such as care homes or A&E staff.

## Evidence Session on 7<sup>th</sup> March 2016

### APPG Officers

- The Rt Hon Sir Kevin Barron MP, Chair
- Oliver Colvile MP, Vice Chair
- Baroness Cumberlege CBE DL, Vice Chair
- Paula Sherriff MP, Treasurer

### Pharmacy Bodies

- **Sue Sharpe** OBE, Chief Executive Officer, Pharmaceutical Services Negotiating Committee (**PSNC**)
- **Sandra Gidley**, Chair of English Pharmacy Board, Royal Pharmaceutical Society (**RPS**)
- **Rob Darracott**, Chief Executive, Pharmacy Voice (**PV**)

### Overview

This All-Party Pharmacy Group meeting served as the second evidence session in the APPG's inquiry into Primary and Community Care: *How can service improvements be achieved and where does pharmacy fit?*

Sir Kevin Barron welcomed those giving evidence and noted that the Group's inquiry had been materially affected by the letter of 17 December 2015 from DH/NHSE to PSNC. He explained that the purpose of the evidence session with PSNC, PV and RPS was to hear their thoughts on the letter; including what developments there have been since it was sent and what they wished the government do in relation to the issues it raised.

Sir Kevin noted that the APPG will be holding the third evidence session on 16 March and that the Minister, the Rt Hon Alistair Burt MP, and Dr Keith Ridge would be giving evidence.

Sir Kevin asked each witness to give the Group their view on the December letter.

### Sue Sharpe (SS) introduction

- SS stated that she felt the letter was a disappointment, as PSNC have been working hard with the NHS closely for years to develop clinical services in community pharmacy and to make sure the sector really delivers. In her opinion, the letter ran contrary to all that work.
- She explained her understanding that the £22bn cuts will be a challenge to the NHS, but the letter showed a lack of knowledge of the sector and a misunderstanding of how people use community pharmacies. She also stated that the letter went much further than a cut in funding in 2016/17 and that it appeared to position community pharmacy as little more than a medicines supply service. She described it as a massive missed opportunity in her opinion.
- She told the meeting that PSNC had been working with other pharmacy bodies to raise the profile of community pharmacy and to express concerns about the content of the letter. She spoke of the cross-party support in Parliament as well as from members of the public and GPs who feel it would be a huge mistake to implement changes that would see many pharmacies close.

### Sandra Gidley (SG) introduction

- SG agreed that in her opinion the letter represented a missed opportunity. According to her, the DH had previously spoken about putting pharmacy at the heart of the NHS, and the RPS had highlighted areas in which the profession could improve efficiency and save money, for example through read-write access to the patient record, named pharmacists in care homes and pharmacists working in GP practices or A&E. She stated that the letter appeared to ignore much of this and lacked any indication of how such initiatives would be achieved.
- She highlighted that there was little engagement between pharmacy and vanguard sites and that more generally at local level there were significant barriers to commissioning pharmacy services.
- She referenced the “You Choose Pharmacy” scheme which had just been launched in Wales, and includes a minor aliment scheme and out of hours support, showed what is possible.

### Rob Darracott (RD) Introduction

- RD agreed that the letter represented a missed opportunity. He said that the detail of the letter is confusing, and the 6% cut in funding is worrying.
- He said that in his opinion the proposals in the letter will not deliver what the Government wants. For the sector to move forward, he said, there needs to be a shared vision for pharmacy and the letter did not represent that. For him it represented a massive challenge to the consensus that pharmacy could and should play a greater role in managing patients’ health and wellbeing.
- He highlighted that pharmacies on average receive 90% of their funding from the NHS and the sector is not going to be able to make up the shortfall following the proposed cuts. He noted great concern about how PV members and others would respond to such cuts.
- He stressed that there are excellent examples of pharmacies which have innovated successfully and that the sector as a whole is developing in a positive way. However, he felt the approach set out in the letter will not support this innovation.

### Developments since the announcement

- SS stated that her biggest concern since the letter had been the lack of detail and the lack of analysis behind the government’s proposals.
- SS stated that thus far, PSNC had not been given enough information to be able to give an informed response to the proposals.
- PSNC had published its own service development proposals in the absence of any in the December letter. Overall, she felt that DH and NHSE seemed lukewarm about advanced or nationally commissioned services, preferring local commissioning despite the evidence that this was hugely problematic.
- SG stated that while PV and RPS were initially invited to play a significant role in the conversations with DH, to date they have only had one meeting, despite their submission to the consultation raising a number of concerns. She explained that they have not been privy to the same information as PSNC, despite asking for it.
- SG also stated that as they understood it, there was going to be a further round of discussion with RPS and PV in later March, but to date they have not been contacted about this.
- SG stated that she felt the process was worrying and opaque.
- RD said he was concerned about the process as he and his organisation have not been told what the next steps are.

## The Access Scheme

- SS stated that PSNC had requested details relating to the pharmacy access scheme, but has yet to be provided with adequate answers.
- SS said that she had initially assumed this scheme was focused on rural pharmacies, but had since been informed that it would include pharmacies in areas of social deprivation or areas where the public had reduced access to healthcare.
- SG raised concerns about the closure of pharmacies in ‘under-doctored’ areas, despite initially being told this would not happen.
- SG also pointed out that the scheme was likely to be complicated. She argued that the more complicated it is, the harder it will be to make sure pharmacies and local communities are being treated fairly and whether they are receiving the right amount of support.
- Finally, SG’s biggest concern was that no account would be taken of quality and therefore, this would be an opportunity missed to drive up standards.
- RD highlighted how complex the process will be and that it will be a huge job to make this work in an effective manner.

## The Integration Fund

- SG highlighted that lack of detail around this, but said the plan seems to be to use pharmacists in conjunction with other healthcare professionals and to develop new roles for pharmacists in different settings.
- SG discussed the recent campaign launched by RPS to get named pharmacists into care homes, which she stated could save the NHS £135m a year. She explained that evidence so far suggests having a pharmacist in a care home helps to reduce the amount of medicines people are taking, which directly reduces the number of hospital admissions.
- SG saw opportunities here, but stressed more details are vital.
- RD confirmed that *if* the integration fund was linked to the concept in the Five Year Forward View of supporting innovative local leaders – then it is something those local leaders would be interested in as there were plenty of examples of good innovative ideas in pharmacy.

## Clusters of pharmacies

- SS acknowledged that there were clusters of pharmacies in some areas, but these were mainly in London and other major metropolitan areas. She explained that the reasons behind this were complex, but it was often the case that in affluent areas such pharmacies were providing non-NHS prescription medicines and over the counter sales.
- SG stated that there were some opportunities within the letter, and it might be that some pharmacies could be encouraged to merge. She stated that this could result in more 24 hour pharmacies and also could support the network of urgent and emergency care pharmacies where the public could go first, ahead of going to the A&E.
- RD argued that clusters can be advantageous as some pharmacies can offer a specific service to a group of people, such as ethnic minorities. He explained that it would be easy to look at a map and see clusters, but we should not draw conclusions without fully understanding why these clusters have emerged.
- RD stated that the sector is starting to see specialisms emerge within particular pharmacies and this should be encouraged.



## Prescription duration and the focus on prescription volume

SS stressed the importance of using pharmacies to work with patients closely, in order to address their specific medicine (and wider healthcare) needs. In her opinion for this to work, it was important to remove the incentive for pharmacies to dispense high volumes of medicines and allow them to use their best skills to manage the health of the patients.

- SG confirmed that some patients receive prescriptions for 90 days, but it's very much on a patient by patient basis and this needs to be managed through a relationship between pharmacist and patient.
- SG also raised concerns that increasing the period of treatment to 90 days could exacerbate the problems already caused by medicine shortages.
- SG expressed frustration at the lack of evidence regarding this proposal and the lack of an impact assessment.
- RD highlighted the waste which would be associated with 90 day prescriptions - as more medicine would be thrown away. For him, the government's objective should be to support people in using their medicines more effectively, and it was clear that community pharmacies had a pivotal role to play in that.
- SS was also asked whether it was her understanding that the proposed cuts would affect dispensing doctors. She stated that she had asked this question of the DH and they had not yet confirmed the position.

Sir Kevin Barron thanked all the participants and closed the meeting.

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. It is recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. PSNC works with NHS England and other NHS bodies, and with the Department of Health, to promote opportunities for the development of community pharmacy services, and negotiate the contractual terms for the provision of NHS community pharmacy services.

Pharmacy Voice (PV) is an association of trade bodies, which brings together and speaks on behalf of community pharmacy in England. It was formed by the three largest community pharmacy owner associations, providing a unified voice for community pharmacy. Pharmacy Voice speaks for the contractors of some 11,000 pharmacies that together employ around 80,000 people.

The Royal Pharmaceutical Society (The RPS) is the professional membership body for pharmacists and pharmacy in Great Britain. It produces professional guidance and support tools to develop and supplement their members' skills and knowledge. It also supports its members with professional recognition through the RPS Faculty, enabling them to gain recognition for their level of practice by employers, commissioners, patients and the public.

## Evidence Session on 16<sup>th</sup> March 2016

### Parliamentarians

- Rt Hon Sir Kevin Barron MP, Chair of the APPG
- Oliver Colville MP, Vice-Chair of the APPG
- Paula Sherriff MP, Treasurer of the APPG
- Dr Sarah Wollaston MP
- Steve Pound MP
- Derek Thomas MP
- Rachael Maskell MP
- Karin Smyth MP

### Department of Health & NHS England

- The Rt Hon Alistair Burt MP, Minister of State for Community and Social Care
- Dr Keith Ridge CBE, Chief Pharmaceutical Officer, NHS England

KB welcomed the Minister and Dr Ridge and thanked them for attending the meeting. The letter of 17 December 2015 from the Department of Health and NHS England to the PSNC had a direct and major bearing on this inquiry, and today's session was an opportunity to explore the implications and current position. KB invited the Minister (AB) to make some opening remarks and anticipated that he may wish to discuss the duration of the current consultation period.

AB thanked the Group for the opportunity to meet and was grateful for the Group's interest. There was real potential to make greater use of community pharmacy and to learn from and build on the great work some pharmacies are doing. He explained that he wished to pave the way to move pharmacies and pharmacists into the heart of the NHS, and the government's plans were intended to enable this. He emphasised that he wished to see pharmacists practise more clinically regardless of the setting.

Spending on health continues to grow. The government had committed to a £10bn real terms increase in NHS funding in England between 2014 and 2020/21 - £6bn of this will be delivered by the end of 2016. The NHS, however, had set itself a target of £22bn of efficiency savings which is set out in the Five Year Forward View and AB said that he would not shy away from the need for cost reductions within pharmacy in contribution towards that. Community pharmacy funding in the coming year will be £2.63 billion, still a significant sum. The government's proposals were designed to improve services for patients and the public, and to secure efficiency and savings.

AB acknowledged that the consequence of the changes may be some closures of community pharmacies but that was not the government's aim.

He explained that the government was consulting on a Pharmacy access scheme, which would help provide NHS funding to pharmacies based on population need and location, the aim of which was to ensure that the public would not be deprived of access to community pharmacies. The aim is to ensure the pharmacies which people depend on continue to thrive. AB recognised that the proposals had caused some uncertainty and concern. He was able to announce that the current consultation period would be extended by two months and would now close on 24 May 2016.

The consultation on the pharmacy integration fund, however would close as planned on 24 March. This was to enable funding to be put in place as early as possible in 2016/17. There will continue

to be opportunities for discussion around the fund and its arrangements until the fund is formally established.

Under the new timeframe for the consultation AB said that he was hoping to confirm the government's position by June and implement by October 2016.

KR circulated copies of a document he had prepared and summarised it verbally.

He highlighted the importance of medicines – they represent the most common therapeutic intervention and the NHS spends £14bn on medicines each year. He questioned whether the NHS gets best value out of that spend in terms of outcomes and highlighted challenges such as the growth of polypharmacy, patchy uptake of new medicines and antimicrobial resistance.

KR suggested the focus needs to shift from the cost containment approach behind medicines management to an approach of medicines optimisation, geared to improve outcomes.

This would reduce waste, particularly in primary care. Overall there was inadequate review and monitoring of medicines. KR said he was grateful to the Royal Pharmaceutical Society for creating a framework for medicines optimisation, and emphasised his view that pharmacists have the clinical skills necessary to markedly improve outcomes from medicines.

But, in community pharmacy about 60% of pharmacists' time is spent on dispensing, which was in his view a functional activity. KR said that now was the time to enable pharmacists to perform more clinical, less functional roles and to integrate pharmacy into the NHS in a variety of different settings (GP practices, care homes, NHS 111, internet based, and urgent care).

The demand for medicines was increasing and yet there were budget constraints.

Genomics will create an opportunity for personalised medicine that will deliver more effective treatment, but it will be costly and therefore medicines optimisation will be all the more important in future. KR argued that pharmacy had a key role to play in this respect.

The direction of travel around strengthening clinical practice and medicines optimisation is similar in the case of hospital pharmacy, as set out in the Carter report.

Turning to funding, KR stated that if dispensing is regarded as a non-clinical activity, then 95% of current community pharmacy service funding is for supply.

There has been a significant increase in the number of pharmacies in England and to a large extent that has been paid for by the NHS. 40% of pharmacies are in clusters of three or more, meaning that two-fifths are within 10 minutes' walk of two or more other pharmacies. All are supported by NHS funding.

KR stated that the government's proposals were designed to integrate community pharmacy and pharmacists more closely within the NHS, to make the process for ordering prescriptions and collecting dispensed medicines more convenient for the public, to simplify remuneration and to enhance efficiency by extending prescription durations where appropriate.

They are looking to modernise the system overall using digital means for how patients receive their prescriptions. The proposals will ensure the infrastructure is the most efficient it can be. This means hub and spoke – which is well established in many other countries and is coming this way.

KR explained that they also wanted to increase the duration of prescriptions where safe and

clinically appropriate to do so, with greater convenience for patients.

Good access to pharmacies will be maintained through the Pharmacy Access Fund, but KR added that there were more pharmacies than was necessary to maintain good access.

Sir Kevin Barron agreed that there was an opportunity to develop and strengthen medicines optimisation, and likewise lifestyle interventions. But the cloud of funding cuts was hanging over all of the government's proposals. There was also concern that there had been a lack of engagement with stakeholder organisations. Two of the pharmacy bodies who gave evidence to the Group the previous week had only had one meeting with the government over its proposals. PSNC had told the Group that it was still in the dark on the details of the process. KB asked how matters had reached this point.

On funding cuts, AB stated that the government was striving to fund the NHS. More resources have been committed, based on the Stevens plan which includes both investment and efficiencies. Savings have to be found across the board, including within pharmacy. It would be ideal if new money were available to fund new developments, and he reiterated that £2.63bn of funding was still substantial. But savings were being found throughout the NHS and that would need to include pharmacy.

AB added that necessity is the mother of invention and now is the opportunity to see what can be done with pharmacy. By changing the flow of money, he expected to see innovative developments as well as efficiencies. Many pharmacists were keen to develop and innovate. The debate should not be entirely about a reduction in funding.

AB stated that the spending review was settled and that the Department and NHS England were talking to the PSNC about how to achieve the savings that were proposed.

He argued that much has changed in the last 30 years. It was now a different world and there were new opportunities for pharmacy. It would not be fair to other sectors of the NHS if pharmacy were excluded from the necessary changes.

KB noted that 30 years ago community pharmacies received far less of their income from the state. Today the proportion was around 90%. He asked the Minister to reflect on that.

Paula Sherriff MP (PS) encouraged the minister to communicate wherever possible with PSNC and other pharmacy bodies. They had good ideas for achieving savings without affecting services, particularly those for vulnerable people. She noted that the pharmacy bodies had concerns about the evidence base and the modelling behind the government's proposals and asked whether the extension to the consultation period provided enough time to consider the proposals properly.

AB said that there had been a good level of responses so far and respondents were coming forward with good ideas. Extending the consultation had demonstrated good faith on the government's part, but it could not be extended beyond 24 May for legal reasons if they are to make the changes by October 2016 – which they are bound to do. He added that the government was negotiating with PSNC, and that Pharmacy Voice, Healthwatch and others are also part of the consultation.

On the subject of hub and spoke dispensing, KR stated that automation is commonplace, particularly in dispensing in hospitals where robots are often used. It makes the process efficient and safer. In community pharmacy in the UK, unlike elsewhere, such automation is not common. In addition to enhancing safety, it enables pharmacists' time to be freed up for clinical interventions.

PS pointed out that that was only one element of these proposals and reiterated her request for more effective communication, during the extended consultation period.

AB confirmed that the government was having various good conversations with stakeholders. There were some fixed views, but constructive discussion was taking place.

Stephen Pound MP (SP) argued that community pharmacy was at the heart of the NHS already and that the face to face contact with patients that it facilitated was precious. He felt that there were several assertions in KR's document and asked for the sources and evidence.

AB said that it was not his expectation that robot dispensing would replace face to face contact between patients and community pharmacists and their teams. Face to face contact was important.

The government's proposals were intended to enable pharmacists' time to be spent on such interactions rather than on the task of dispensing.

KR added that the assertions were well-sourced and agreed to send that information to the Group.

Sarah Wollaston MP (SW) raised three points. Firstly, she asked for reassurance on the future of rural pharmacies under the government's proposals. Secondly, she raised a concern about the security of personal data, especially in light of the recent Pharmacy2U case, and asked what information security obligations pharmacy would work under. Thirdly she asked what would be done to train the pharmacy workforce to take on this clinical challenge.

On rural pharmacies, AB stated that it was the government's intention to ensure that the public had good access to a pharmacy. He was not in a position to confirm details of the Pharmacy Access Fund as it was a matter of negotiation, but he added that it must not be an arbitrary arrangement and that there would be a transparent national formula.

SW asked whether there would be a backstop for rural pharmacies if the Access Fund does not help them.

AB said that the government was planning on the basis that access is not lost. The Access Fund would, in effect, be the backstop.

On workforce training, KR stated that the Centre for Postgraduate Pharmacy Education had been commissioned to work with pharmacy and general practice to create a programme to orientate pharmacists to general practice. The first "boot camp" had taken place recently.

SW asked that the Group be sent more details in writing on this initiative to which KR agreed.

KR added that some Integration Fund resources would be used in 2016/17 to explore what more could be done to address education requirements. But it would also be necessary to consider carefully, together with commissioners, the services that were to be commissioned. He stated that he would be carrying out a review over the next few months to look more thoroughly at this.

On SW's point about data security, KR agreed about the importance of getting this right. Pharmacists and pharmacy premises are regulated by the GPhC. There are also information governance rules. This provided a basis for a robust approach to data security. Individual issues were a matter for the GPhC.

Oliver Colvile MP (OC) observed that there seemed to be positive opportunities for pharmacists in the government's proposals, but there may well be a reduction in the number of pharmacies. He

asked for more details on the practicalities on the Pharmacy Access Fund.

AB said that the intention of the Access Fund was that those pharmacies that would be vulnerable due to reduced funds in isolated areas would receive extra funds.

OC asked when more details would be available.

AB said he expected that would be towards the end of the negotiating period and reiterated that there must be a legal basis to the fund. It cannot be arbitrary.

KR added that the scope of the Access Fund would take into account isolation and demographics.

OC asked how the government would ensure that if a pharmacy closes its place is not immediately taken by another opening.

KR replied that this was a matter under discussion with the PSNC.

OC raised the matter of the decriminalisation of dispensing errors. He asked why pharmacists in England needed to wait for the elections in devolved countries to take place before this matter could be resolved.

AB replied that the Section 60 Order which is required relates to the regulation of pharmacists in all the home nations, and will be laid as soon as possible. He expected that to be not before the autumn.

KB asked whether there would be a system of compensation administered compassionately, especially for independent pharmacies who may be locked into leases and other financial commitments.

AB said that he had not seen evidence on that point so far, but that it remained to be considered. He understood the concern that KB had raised.

KB closed the meeting by thanking the Minister and Dr Ridge for attending.

**Following the APPG's evidence session, Dr Ridge offered the following clarification on comments he made during the meeting on dispensing error rates in community pharmacy vs. automated systems.<sup>2</sup>**

"You may recall I carefully said in advance of my statement that error rates depend on methodology and error definitions used. The DH's impact assessment bibliography has two key references. First it tries to utilise data from the National Reporting and Learning System. This is a self-reporting methodology and will inherently lead to under reporting of the true rate. To add to this, you will be aware that there has been a problem of under-reporting of errors from primary care in general. This is further complicated within community pharmacy because of the commercial nature of the sector. Probably the key reference is James et al (p27 of the IA). This is a review from 2009. The only UK observational study of dispensing error rates within that paper quotes a rate of 3.32%. One of the authors of that paper is Bryony Dean Franklin, now Professor Bryony Dean Franklin FFRPS, Executive Lead Pharmacist Research & Director, Centre for Medication Safety and Service Quality, Imperial College Healthcare NHS Trust. Bryony is one of the world's experts on medication error

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<sup>2</sup> Following Dr Ridge's appearance, PSNC submitted a briefing to the officers of the Group, challenging aspects of his evidence. This briefing is available here:

research. In advance of the APPG hearing I spoke to Bryony who confirmed that in her view 3% remains about the dispensing error rate in community pharmacy, taking into account methodologies and definitions used, although there remains a paucity of good research. Bryony is aware of your request for clarification.

“Turning to large scale automated dispensing facilities, and my reference to an error rate of 0.00001%. I was referring to the error rate published by Apotekstjänst AB in Sweden – in fact the published rate is 0.0000185%. All Swedish pharmacies are required to publish the rate as part of patient safety initiatives.

“However your request for clarification has made me ask further questions. I now know the data from Sweden is a reported error rate, and not determined by observation. In fact, this rate represents the % number of errors in single pouches reported by external parties (eg doctors, nurse, patients) as a proportion of the produced pouches. In 2015 Apotekstjänst AB produced 96 million pouches.

“It is also important that I clarify the Swedish facility I referred to dispenses into "pouches" of medication. This is not routine practice in the UK.

“In conclusion, there is observational evidence of dispensing error rates in community pharmacy of around 3%. Now that I know the error rate from Sweden is determined by reporting, it is not appropriate draw a direct comparison. I apologise for inadvertently misleading the committee and for any subsequent confusion.

“However, I do remain of the view that automated centralised dispensing, underpinned by a robust quality assurance and regulatory system, resilient and implemented carefully, will improve safety and quality of patient care. Therefore I have been in contact with Apotekstjänst AB to ask for further data. The company is content for the data to be in the public domain.

“The automation used by Apotekstjänst AB works by packing one or more different tablets into individual pouches. Each pouch contains an individual patient’s requirements for a particular time of day. The content of each pouch is then checked for the right content using sophisticated photographic technology. In the previous 12 months out of 92,216,705 pouches produced, 2,542,759 (2.99%) were rejected and then inspected manually. The manual inspection is supported by further computer technology. Of the rejected pouches, 97.67% were “false errors” – mainly tilted tablets on top of each other giving incorrect photos. The number of errors which are then further checked by a pharmacist in the hub was 59,317 (0.32%). I understand the main error types that fall into this category are broken tablets or tablets which have ended up in the next pouch within the original automated dispensing process. I also understand that any errors remaining which are then reported by external parties have been found to be mainly due to manual interventions in the production process (e.g. incorrect manual inspection by pharmacists). It is also interesting to note that I understand the Netherlands have largely eliminated traditional “multidose systems” and replaced those with a similar centralised, pouch dispensing system.

“I would like to confirm that I am neither trying to promote any approach to centralised and automated dispensing, nor any specific technology, and I fully acknowledge the data I am quoting is from only one site. I do however believe this example from a country with a decade or so experience (as there is in the Netherlands) in such processes does serve to illustrate some of the potential benefits, if the UK implements and utilises relevant technology in a considered manner, including drawing on the experiences of other countries.”



## Evidence Session on 10<sup>th</sup> May 2016

### Parliamentarians

- Rt Hon Sir Kevin Barron MP, Chair of the APPG
- Oliver Colvile MP, Vice-Chair of the APPG
- Rt Hon George Howarth MP
- Barbara Keeley MP
- Nic Dakin MP
- Kelvin Hopkins MP
- Tom Blenkinsop MP
- Stephen Pound MP

### Witnesses

- Sarah Hutchinson, Policy Advisor, National Voices
- Kayleigh McGrath, Senior Policy and Public Affairs Officer at Carers UK
- Izzi Seccombe, Chair of the LGA's Community and Wellbeing Board

Sir Kevin Barron MP (KB) welcomed the witnesses and thanked them for giving evidence in the APPG's inquiry.

He reminded the witnesses that when the inquiry was launched the purpose was to see if and how pharmacy could play a greater role improving efficiency in the NHS, by helping to reach the targets set out in the Five Year Forward View. However, he explained that the letter of 17 December 2015 from the Department of Health (DH) and NHS England (NHSE) to the PSNC had a direct and major bearing on this inquiry, and today's session was an opportunity to explore the implications of the government's proposals and the witnesses' views on them.

KB began by asking if any of the organisations had been involved in the consultation and if they had been contacted by the DH about the proposals.

Sarah Hutchinson, Policy Advisor, National Voices (SH) confirmed that her Chief Executive was invited to a recent stakeholder event held by the DH. She has also been informed about the proposals through some of their members, and by the Royal Pharmaceutical Society (RPS).

Kayleigh McGrath, Senior Policy and Public Affairs Officer at Carers UK (KM) stated Carers UK have not responded to the consultation, but welcomed the opportunity of this evidence session to share their thoughts on the impact of these proposals on carers.

Izzi Seccombe, Chair of the LGA's Community and Wellbeing Board, (IS) had been contacted by DH and confirmed that local authorities see it has a very important issue. The key messages which they have relayed back to the DH have been around the important role community pharmacies play in supporting isolated and venerable people; the greater role which they should be playing in supporting communities and people at home; and to the role they play in providing high street access to health and well-being services.

KB then asked what more could be done by community pharmacies to keep people at home and out of hospital.



For Carers, KM spoke about how community pharmacies play a vital role in practical day to day support for carers, including advice and information for the cared for person regarding the medicines they are taking. She noted that pharmacies also provide helpful information for carers themselves, and the service is both very accessible service and often less formal than an appointment with the GP.

KM also noted that pharmacies can signpost people to local carer centres and carer assessment centres. Carers UK's evidence shows that out of all the services on the high streets, carers have rated pharmacies as the most friendly and approachable.

SH stated that many of the people that National Voices support have long term conditions and it is the face to face contact they appreciate in pharmacies. People with long term conditions will often see their pharmacist more often than their GP, and community pharmacists can help them self-manage and reduce unnecessary visits to GPs and hospitals.

SH felt that pharmacists should be given the opportunity to be doing more in public health – such as supporting people to stop smoking.

Oliver Colvile MP (OC) asked for views on the RPS's proposal that individual pharmacists should be designated to a care home.

SH she felt it could be a good idea. She mentioned that people in care homes are often prescribed a variety of medicines and the involvement of a pharmacist in regularly assessing the patient's medicines is very helpful – especially if it reduces pressures elsewhere in the health service. This could be optional for residents who may choose an alternative pharmacist, but would make access and overview of medicines easier.

IS said she did not have a significant issue with this, but did feel that it would need to be a fair and transparent arrangement and that patients would need to have a choice. She also raised a concern about the commercial arrangements between care homes and pharmacies, which in she underlined by stressing the need for transparency and choice.

Barbara Keeley MP (BK) said that during Carers Week she spent time with pharmacy staff providing a free medicines collection and delivery service to patients at home and was struck by the close relationship they had with carers and those they cared for. She wondered if putting pharmacists in GP practices this would limit this.

KM said there were underlying concerns that carers would lose access to pharmacies which they value at the moment and that it could be more difficult to see a pharmacist based in a GP surgery. She noted that an important aspect of pharmacies was their location, and if they were to decrease in rural areas it could badly impact carers in such areas who may have to travel much longer distances to access services from, say, GPs or other providers.

IS said the LGA was keen to encourage pharmacies to expand their services and provide more support to patients and the wider public. Local authorities already commission public health services from pharmacies – such as smoking cessation, sexual health services and lifestyle advice. She noted that young people who might not always want to go to their GP, but benefit from the accessible service that pharmacies offer on the high street without the need for an appointment.

SH highlighted that the funding cut proposed by the government would reduce public health services first which are very important to the organisations that National Voices represents. She felt a reduction in services provided by pharmacies would reduce their ability to achieve the aims set out in the Five Year Forward View. She felt that, on the contrary, services from pharmacies should be expanded.

Stephen Pound MP (SP) expressed his concerns about locating pharmacists in residential homes as it would be placing the community pharmacist in a different commercial setting and limit choice. He also noted the growth in services offered by community pharmacists and wondered if it was an organic growth encouraged by pharmacy itself. He noted, however, that the general public are not fully aware of the range of services that community pharmacies offer.

KM noted that carers are twice as likely to be in poor health than the rest of the population as they often put their own health needs below the person who they care for. They do not always have the time to visit a GP as they are busy caring. That makes the accessibility of community pharmacies all the more valuable for them.

SH suggested that one way of helping to raise awareness of what pharmacies can offer would be for GPs, where appropriate, to tell the patients they see when that could have received treatment at a pharmacy and encourage them to visit one in future.

IS spoke about the expansion of Healthy Living Pharmacies, which the LGA supports and referenced a paper that it had published, [The community pharmacy offer for improving the public's health: a briefing for local government and health and wellbeing boards](#), which sets out additional ways in which pharmacies provide advice and support for local communities. She noted that services were developing organically at local level and cited a local initiative in Worcester, which has proven extremely helpful in driving local engagement. She promised to send SP further information on this.

KB noted that it is rare to see pharmacists on Health and Wellbeing Boards. IS agreed and said that this is a challenge. In her own locality, there is not a pharmacist on her HWB, but local pharmacists do engage with it.

Kelvin Hopkins MP (KH) spoke about the importance of protecting community pharmacies and the integral role they play in supporting the health of the public in local communities. He explained his concern was that the proposed cuts might be at the expense of independent pharmacies rather than multiples.

Tom Blenkinsop MP (TB) asked about the impact of the government's proposals on young people and especially young carers. KM did not think there had been an impact assessment on how different groups would be affected. She pointed out there are some aspects of the proposals which have the potential to help carers, such as online ordering and click and collect. However, it would still be important for carers to speak directly to pharmacists face to face.

Barbara Keeley MP (BK) felt that there had not been an effective strategy of involving pharmacy within the new structures of the NHS at an early enough stage in the past, and this should be learnt from.

IS stated that at the moment local authorities are developing Sustainable Transformation Plans (STPs) and it would be a missed opportunity if pharmacy were not to be part of this process. She

also noted that the proposals for a pharmacy integration fund and suggested this fund should be managed by local authorities as they have a good understanding of local circumstances and needs. .

OC noted the importance of reducing pressure on over stretched GPs. He suggested one way to do this is to give pharmacists greater access to summary care records and encourage better coordination between pharmacists and GPs.

SH agreed with OC and explained that it was part of National Voices' pre-election 'manifesto'. She also stated that it would be very helpful in building relationships between GPs and pharmacists and also the voluntary sector.

KM explained that coordinating care is very stressful for carers and sharing patient records would be of great help.

KB thanked the witnesses for attending and closed the meeting.

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