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Jeannette Howe
Via Email

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13 October 2016

Dear Jeannette,

COMMUNITY PHARMACY IN 2016/17 AND BEYOND NEGOTIATIONS

I am writing to communicate the decisions made by PSNC at its meeting on 11 and 12 October, in response to your letter dated 9 September. This set out the proposed package which is broadly consistent with the proposals you set out in May with an adjustment to take account of the delay in implementation, and indeed in the most important respects it is unchanged from the proposals set out in your letter of 17 December 2015. Unlike the 17 December letter, your letter of 9 September was marked "In Confidence", but I note that the Government has since provided information about the proposals more widely, so I have not marked this response as confidential.

Since receipt of your letter dated 17 December 2015, we have sought to obtain from you the rationale and evidence we need to allow an informed consultation. In the intervening months some aspects of the proposals have become clear, but the details of the underpinning rationale and analyses, and information about other options considered and why they were rejected have not been provided. Unlike the collaborative working that characterised previous negotiations with you, we have been delivered a fait-accompli. In my letter dated 8 February I asked why you made the decision to reduce pharmacy remuneration, and why there was no consultation before that decision, as has always been the case in the past. I received no answer.

Through this year we have sought to work collaboratively with you, and we regret greatly that you have made that impossible. It has been clear that decisions had already been settled and on the principal issues there was no real consultation.

In meetings with the previous minister, Alistair Burt, and with David Mowat, we have articulated our commitment to work to deliver our long-held ambition to increase the services and support pharmacies provide to our patients and communities and to extend those discussions to consider the current pharmacy network and whether it needs to be re-shaped to ensure that care is provided where it is needed. We have long wanted, and continue to want, to see a service based contract and funding systems. Your proposals for a single activity fee for supply run counter to this. Our offer of productive engagement across these areas has been ignored.

More than two years ago the Government's ambition to close pharmacies was confirmed by the Chief Pharmaceutical Officer, when he said that we have 3,000 too many pharmacies. At the end of 2015 the Government was clear that its aim was to reduce numbers. The 17 December letter states that "In some parts of the country there are more pharmacies than are necessary to protect good access". Most recently the Government has retreated from this, and you have said that there is no aim to close pharmacies although you recognise pharmacies may close as a consequence of your proposals. This is just not credible in face of the approach taken in the proposals.

We commissioned PwC to undertake an economic evaluation of some of the services community pharmacy provided, to help the Government make decisions based on information it did not have and had not sought. For the twelve services it assessed, with very conservative evaluations, the figure for the in-year benefit alone was in excess of £3billion, more than the total annual funding for the community pharmacy service. This had no impact on the Government's position.

In September Durham University produced a study showing that today more pharmacies are found in areas with the greatest health inequalities compared with more affluent areas, which surely is where we need them? But this too has been ignored by the Government.

In the spring of this year, in an effort to work collaboratively and find means of making savings for the NHS, we put forward proposals that would increase pharmacy services and reduce burdens on other parts of the NHS, and also proposals that would reduce the cost of medicines to the NHS. Pharmacies of course already deliver large savings from their procurement work, which are passed through to the NHS. Both our service proposals and our cost-saving options were rejected, we believe, because the benefits would be seen in CCG budgets and not centrally held funds. This is not good policy making.

There is plenty of evidence that pharmacies can provide care and advice at considerably lower costs than general practice or urgent care services, where demands will be diverted as pharmacies become unable to meet patients' needs.

Your letter confirms that in 2017-18 you will set pharmacy remuneration at £2.592bn, a reduction of 7.4% on the current level. You will reduce funding for 2016-17 from December 2016 to March 2017 to £2.687bn, cutting average pharmacy funding by 12% compared with the present levels for those four months. You state that you want to "ensure contractors are given a reasonable amount of notice…". To suggest that six weeks' notice of such a reduction is reasonable is preposterous.

In 2010 the Department of Health commissioned PwC to undertake a comprehensive Cost of Service Inquiry for community pharmacy. The Minister was unaware of this study when we met him recently, but as you know, it showed the costs of pharmacy then to equate to £3.03 per prescription item dispensed for the average pharmacy. More than 1bn items are dispensed in community pharmacies in England a year, equating, on 2010 prices, to over £3bn, ignoring the significant increases in costs since then. You are committed to funding at a level well below those 2010 costs.

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We understand that the Government wishes to see fewer, large volume pharmacies, but no evidence has been provided that they would reduce costs, or would provide the services currently delivered to our patients and communities.

The proposals were and remain, founded on ignorance of the value of pharmacies to local communities, to the NHS, and to social care, and will do great damage to all three. We cannot accept them.

Specific issues

You have made public proposals for a pilot emergency supply service. We support this although we have not yet been able to analyse whether the proposed funding will be sufficient. This is of course simply a pilot, and needs to be properly designed and implemented. It seems that your decision to announce this and the terms of the announcement are an attempt to present this as a substantive and important proposal, conflating it with a minor ailment service which is of course not being commissioned. Using community pharmacies to help patients get quick, effective access to care for minor ailments, reducing the demands on general practice, offers cheaper, quicker, more effective care, and your refusal to commission a national minor ailments advice service from community pharmacies reflects badly on the Government's concern for our communities and for the NHS.

The 17 December letter spoke of plans to introduce a Pharmacy Access Scheme (PhAS) to protect patients' access to community pharmacies. The proposals you have set out do nothing to protect the pharmacies in areas of the greatest health need or those with high ethnic minority populations who often depend on the pharmacist to get advice in their own language. The support within the proposed PhAS is directed towards pharmacies in more affluent areas. Our detailed response is set out in an appendix to this letter, but we cannot agree that these proposals are fair or balanced.

As part of the alternative proposals referred to above that we put forward, we offered to introduce a Quality Payment. This was aimed at rewarding the pharmacies who do the most to help patients and provide the very best care. You have adopted this, but without the service proposals to which it was linked. We are committed to ensuring that we reward and protect pharmacies that do the most for patients, but this cannot impose additional costs and bureaucracy unless it is funded.

Your proposals for funding distribution, and substituting most of the current payments with a Single Activity Fee per item dispensed, are incompatible with supporting those pharmacies that do most to meet the needs of our communities. You made clear last December your determination to remove any element of 'front-loading', although this is standard in NHS contracts. Removal of the Establishment payments targets for the greatest cuts the low dispensing pharmacies in areas with the highest health needs. They would see funding reduced by over 10% next year, at a time when the NHS has said that efficiency targets of 4% are too high to be achievable, and has reduced targets to 2%. This cannot be right.

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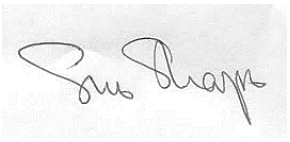
Finally, you propose to implement drug reimbursement changes that we agreed to as a package in 2014, but the one issue on which you need to consult, but have failed to do so in more than two years and which is important to us, is dependent on the consultation and you now propose to take this issue forward separately. You will understand that we have no confidence whatever that this will be implemented. Our policy has been, and remains, to ensure that reimbursement arrangements are fair and allow pharmacies equal access to the funding they receive through allowed purchase margin. Changes must be consistent with this policy.

In conclusion, I reaffirm our willingness to work with you to provide a community pharmacy service that delivers the best possible care to our communities. We believe that, properly used, the community pharmacy network can be key to helping our NHS survive the challenges it faces today. The NHS has resolutely failed to examine this opportunity. The NHS Five Year Forward View demonstrates how little account was taken of the option to use community pharmacies in re-structuring care, and sadly nothing has changed since. The NHS does not understand how people meet their needs for health advice, support and reassurance today, and unless this changes there is little hope it will make wise decisions on spending limited taxpayer funds. We hope that the Government will listen to us.

Yours sincerely



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Pharmacy Access Scheme **Annex**

The proposed 16-month Pharmacy Access Scheme (PhAS), which changed radically in nature on 20 September 2016, is intended to ensure continued patient access to pharmacies, following the cut in funding. PhAS is based on one main eligibility criteria: a pharmacy to pharmacy road walking distance of 1-mile or more. In addition, the largest pharmacies (top 25%) are not included in the scheme. Therefore, those pharmacies 1-mile or more from another pharmacy, for example 1.1 mile away, will receive PhAS payments; those pharmacies less than a mile from another pharmacy, for example 0.9 of a mile, will receive no support or protection from the funding cuts.

PSNC has identified the following 16 objections to the proposed scheme:

1. **A simple scheme does not necessarily make it easy for patients to access pharmacies** - in what way is patient access assessed other than by distance;

2. **Access and the way it is calculated has not been considered properly or fully** – a pharmacy to pharmacy distance of 1 mile or more does not put the patient first, across the whole of the country;

3. **The scheme is not in accordance with the overriding message of the Independent Report into the Mid Staffordshire NHS Foundation Trust that 'it should be patients – not numbers – which count'**; while the report considered different issues, its message was that patients should come first and that '*it is the people working in the health service and those charged with developing healthcare policy that need to ensure this is the case'* (penultimate paragraph of the conclusion);

4. **The urban areas of the country have not been properly considered in terms of patient access, at any stage of this process** - in London there are only 3 PhAS pharmacies selected by your proposed criteria;

5. **In terms of patient access, the delivery of dispensed medicines to patients undertaken by existing bricks and mortar pharmacies has not been considered** – many pharmacies deliver medicines to patients without charge (this is not an NHS service) and are close to the communities they serve;

6. **The rationale for excluding the top 25% of pharmacies from consideration is not explained** - why exclude the top 25% only, why not exclude more;

7. **A scheme to protect access to 700 pharmacies, does not need to protect 1,371, almost twice as many** – if the composite index is the justification for the scheme, 700 should be protected;

8. **The composite index is not fit for purpose because it does not properly take into account 'needs' and 'population'** - genuine, real-world, patient access to NHS pharmaceutical services has not been considered to any meaningful extent;

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9. **The neediest populations in the country are simply not considered to any meaningful extent** – there are only 68 PhAS pharmacies out of the 700 pharmacies serving the neediest populations in the country; in practical terms this means that the 30 most deprived areas in the country have simply been excluded from any meaningful consideration;

10. **The isolation component of the composite index is flawed and inaccurate and dominates the index** – the isolation component is based on measurements from the middle of Output Areas and cannot be relied upon for accurate, real-world distances; of the 700 pharmacies selected by the composite index, 493 are selected by the isolation component on its own;

11. **The composite index is not fit for purpose but is used to justify the selection of the 1-mile pharmacy to pharmacy distance** – having abandoned the composite index, the claims attributed to the index are still being made;

12. **Local Pharmaceutical Services (LPS) pharmacies have not been properly considered and the funding of many of these remains uncertain** - LPS pharmacies, including the former Essential Small Pharmacies, are included in the calculations for the scheme, but the 20 selected are not assured funding;

13. **Local Pharmaceutical Needs Assessments (PNAs) assess the local needs for NHS pharmaceutical services but these have not been considered** – PNAs include a statement of the pharmaceutical services provided that are necessary to meet needs in the area and a statement of other NHS services provided by a local authority, the NHS Commissioning Board (NHS England), a Clinical Commissioning Group (CCG) or an NHS Trust, which affect the needs for pharmaceutical services;

14. **There has been no proper consideration of new pharmacies that might open during the period in question, or pharmacies that might close** – for example, if a pharmacy closes and access to another pharmacy becomes crucial, it will not be protected by PhAS because the scheme is fixed from the start for 16 months;

15. **The Government controls market entry and over the years has allowed the numbers of pharmacies to increase and now wants them to decrease; it should provide compensation** – in 2005, the market was allowed to expand and two years later steps were taken to halt this; and

16. **The scheme appears to select pharmacies that should survive what is likely to be a cull in pharmacy numbers, but it is not an appropriate system to carry out such selection (even if this were appropriate in the first place).**

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