Merge & Close Position Paper

This paper sets out AIM's position in relation to the merging and closing of pharmacies.

Where are we now?/How did we get here?

Pharmacy market entry is governed by the Pharmaceutical Services Regulations[1]. Between 1987 and 2005, new NHS pharmacy "contracts" could only be granted if a restrictive necessary or desirable test could be satisfied.

In 2005, the Pharmaceutical Services Regulations were relaxed to allow pharmacies to obtain an NHS contract without having to satisfy the necessary or desirable test if those pharmacies would be open for at least 100 hours a week.

According to a 2008 White Paper[2], there were:

> "*… considerable problems with this exemption, which can be summarised as a lack of PCT control over where such pharmacies are located; there is no match between the better access that a 100 hours per week pharmacy delivers and the need for such an improvement locally; there is clustering of 100 hours per week pharmacies close to each other or around income sources…*"[3]

In 2009, the Pharmaceutical Services Regulations were amended[4] so as to prevent an application being granted if pharmaceutical services were already being provided at the application site. The reason, according to the accompanying Explanatory Memorandum was as follows:

> "*A loophole is removed which enabled a contractor to apply to provide NHS services at, or move NHS services to, a site where NHS services are already being provided. This can lead to a PCT paying up to twice the normal NHS allowances for what is in effect a single pharmacy...*"[5]

This provision is now in regulation 31 of the Pharmaceutical Services Regulations.

In 2012, when the Pharmaceutical Services Regulations underwent a major change, the necessary or desirable test was replaced by a test linked to local Pharmaceutical Needs assessments, and the 100-hour exemption was dropped.

On 15 December 2015, the Department of Health (now DHSC) announced severe cuts to the funding of community pharmacies. Part of its rationale was that pharmacies tend to cluster[6] together. In an Impact Assessment published by DHSC on 19 October 2016 to coincide with the implementation of the cuts, DHSC assumed that the cuts would result in pharmacy closures but said "there is no reliable way of estimating the number of pharmacies that may close as a result of [the cuts][7]". The impact assessment addressed[8] what it described as "Inappropriate focussing of NHS resources on certain clusters of pharmacy businesses".

In 2016, DHSC amended the market entry regulations to enable pharmacy owners to apply to merge two pharmacies onto a single site[9] (closing one of them) referred to as "merge & close".

In March 2018, DHSC published a review the operation of the market entry regulations. This review noted that 1,135 out of 1,153 100-hour pharmacies were in a cluster.[10]

What are the issues?

From the perspective of DHSC, presumably clustering is still an issue.

From the perspective of all pharmacy contractors, including AIM members, following the implementation of the remuneration cuts announced in December 2015, the viability of many pharmacies is threatened.

Pharmacies need to cut costs.

In tandem with the remuneration cuts, DHSC amended the market entry regulations in 2016 to enable pharmacy owners to apply to merge two pharmacies onto a single site[11] (closing one of them), but an application must be refused if granting it would create a gap in pharmaceutical services provision.

The Explanatory Note to the amendment Regulations says:

> "*If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3). Also, if the NHSCB does grant the application, it must then refuse any further applications known as "unforeseen benefits applications" by other chemists seeking inclusion in the pharmaceutical list, if the applicant is seeking to rely on the consolidation as a reason for saying there is now a gap in provision, at least until the next revision of the PNA*"[12]

Pharmacy owners, especially multiples, could save costs by merging and closing pharmacies that are in clusters. However, pharmacy owners are reluctant to make regulation 26A applications. A survey of AIM members revealed that:

- Respondents had made 9 successful merge & close applications between them.
- Two respondents said they were aware of an application being made for a new pharmacy after a merge & close application had been granted.
- Even those who had made successful applications had refrained from making further merge & close applications because of a worry that someone else would apply for a new contract on the basis that a gap had been created.
- Most respondents would like to merge and close pharmacies but had not made any application because of worry someone else would apply for a new contract following the closure, or because of worry that a new Pharmaceutical Needs Assessment would identify a need for a new pharmacy following a successful close & merge.

In addition to concerns about the effectiveness of regulation 26A, it is not possible for the owner of a 40-hour pharmacy and a 100-hour pharmacy to merge them and then close the 100-hour pharmacy. This is because, regulation 31 of the Regulations does not allow a pharmacy to relocate to a site where there is an existing pharmacy. However, it is possible to close a 100-hour pharmacy if the 40-hour pharmacy and the 100-hour pharmacy have different owners.

As the 2009 Explanatory Memorandum made clear, the restriction in regulation 31 was introduced in order to prevent more than one establishment payment being claimed for the same premises, and relocation applications to the site of a 100-hour pharmacy are being refused[13]^[13] even though, with the phasing out of establishment payments, it would seem that regulation 31 no longer serves its intended purpose. Moreover, although the merge & close provision in regulation 26A extends to cases where both pharmacies are in common ownership and when they have different owners, regulation 31 prevents the closure of 100hour pharmacies when the pharmacies are in

common ownership, but not when they have different owners. There does not appear to be any good reason for this distinction.

AIM position

- NHS funding is insufficient to support the current number of pharmacies.
- Pharmacies are currently closing or likely to close through attrition, and closures are unstructured.
- Pharmacies in clusters could engage in planned closures if they felt secure in making merge & close applications without worrying that closure would be followed by an application for a new contract made either opportunistically, or as a result of a new PNA identifying a gap.
- Almost all 100-hour pharmacies are in clusters, rather than where there is a need for extended hours of service.
- Pharmacies could additionally engage in planned closures if they could relocate a 40-hour pharmacy to the site of a 100-hour pharmacy and close the 100-hour pharmacy.
- Many will find unattractive the idea of enabling pharmacies that took advantage of the 100-hour exemption to close following relocation of a 40-hour pharmacy. However, the economic climate for community pharmacy is very different now to what it was in 2005. Now, the issue is not the profitability of community pharmacy, but its survival.

AIM proposals for future action

The Pharmaceutical Services Regulations should be amended to:

1. Prevent applications for new pharmacy contracts within 800m of a site where there has been successful merge & close application in the preceding 5 years.[14]
2. Revoke regulation 31 of the Pharmaceutical Services Regulations.

Footnotes

[1] The National Health Service (Pharmaceutical Services) Regulations 2005 – now the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
[2] Pharmacy in England Building on strengths – delivering the future - CM7341
[3] Ibid paragraph 8.6
[4] The National Health Service (Miscellaneous Amendments Relating to Community Pharmaceutical Services and Optometrist Prescribing) Regulations 2009
[5] Paragraph 7.2.10
[6] The DHSC Impact Assessment refers to an unpublished paper which appears to be the basis of a paper subsequently published Todd A, Thomson K, Kasim A, et al Cutting care clusters: the creation of an inverse pharmacy care law? An area-level analysis exploring the clustering of community pharmacies in England BMJ Open 2018;8:e022109. doi: 10.1136/bmjopen-2018-022109, in which the definition of a cluster is "within 10 min walking distance of another pharmacy".
[7] For example, paragraph 51 of the Impact Assessment
[8] For example, paragraphs 19 to 21
[9] Inserting regulation 26A of the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013
[10] Paragraph 73
[11] Inserting regulation 26A of the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013
[12] The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016
[13] For example, NHS Resolution decision SHA/19993, 17 January 2019

[14] There is already a precedent in regulation 40 of the Pharmaceutical Services Regulations which bars certain rural applications within 5 years of a previous grant. If a cluster refers to the number of pharmacies within a 10-minute walk, at an average walking speed of 3mph, the distance walked in 10 minutes would be half a mile or 800m.