The Pharmacists' Defence Association's Submission to the All Party Pharmacy Group Flash Inquiry into the impact of Corona Virus on the Pharmacy Sector

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Summary :

The All-Party Pharmacy Group (APPG) was formed in December 1999 to drive forward cross-party conversations on topical issues and their significance for pharmacy, patients and the NHS.

They have instigated a “flash inquiry” looking at both the service and financial impact of Covid-19 on the sector with the following terms of reference :

- How has the pharmacy sector coped and responded during the Covid-19 pandemic, and what additional pressures is the sector facing.
- What level of funding and financial support is needed to address these pressures and has the £370M Government advance payments helped.
- The impact of pre-pandemic financial pressures and of the Community Pharmacy Contractual Framework.
- To what degree has the role of pharmacy in the pandemic been recognised by Government, NHS and the public.
- How has the pharmacy workforce coped during the Covid-19 pandemic and what further support do they need.
- What reforms and support does the sector need to remain sustainable in the future.

They seek a better understanding of these issues from the pharmacy sector and it is on that basis that the PDA (as the largest UK pharmacist membership organisation) makes this submission.

About the Pharmacists' Defence Association

The Pharmacists' Defence Association (PDA) is a not-for profit defence association and trade union for pharmacists. It is the only organisation that exclusively looks after the interests of employee and locum pharmacists across all sectors of pharmacy, currently with a membership of more than 32,000, the PDA is the largest representative membership body for pharmacists in the UK and this membership continues to grow.

Delivering more than 5,000 episodes of support provided to members who have found themselves in a critical incident situation in the last year alone, provides the PDA with a rich vein of up to date experiences which have informed policies and future strategy.

This experience has recently been informed by the very considerable number of Covid-19 related issues being faced by members. The practical experience gained in supporting member issues from the coal face is further enhanced by regular member surveys and focus group interactions. The information in this document is largely built upon the experience of our 32,000 members .

The primary aims of the PDA are to:

- Support pharmacists in their legal, practice and employment needs
- Represent the individual or collective concerns of pharmacists in the most appropriate manner
- Proactively seek to influence the professional, practice and employment agenda to support members
- Lead and support initiatives designed to improve the knowledge and skills of pharmacists in managing risk and safe practices, so improving patient care
- Work with like-minded organisations to further improve the membership benefits to individual pharmacists
- Arrange insurance cover for individual pharmacists to safeguard and defend their reputation.

Context of the impact of Covid-19 on the Community Pharmacy sector.

The PDA represent pharmacists in all parts of the health and care system, this includes hospitals, health boards, prisons, care homes and GP practice. However, the APPG flash inquiry is targeted on community pharmacy and hence that is the focus of the PDA response.

The Covid-19 pandemic has had a profound impact across the UK and has graphically highlighted the health and other inequalities that are prevalent across the UK.

It may surprise readers of this document that even within a supposedly professional setting such as a pharmacy, these health and other inequalities are widespread.

Many pharmacists work for community pharmacies operated by large multinational corporations, others at smaller chains or independent pharmacists. All are registered health professionals engaged to deliver NHS services to the public and thus are no less a part of the NHS than employees of GP practices or many other parts of the system. Yet, the pharmacy team, as within the wider healthcare system, are not always recognised as such and were often exposed to the virus with little or no protection.

Community pharmacies were already under tremendous financial pressure before the pandemic with year on year cuts to funding. Whilst we saw Government write off £13 billion of accrued debt from NHS Trusts, pharmacy only saw an “advance” of some £370 million to temporarily ease cashflow pressures. The financial pressure on smaller pharmacies if this amount is now clawed back could push them towards closure.

The repeated praise for pharmacists and their teams from Government throughout the pandemic now needs to be translated into genuine financial support for the sector which, despite this chronic underfunding, responded dynamically and positively to ensure that patients were not disadvantaged or put at risk due to these immense financial pressures.

In particular, pharmacists :

- Were open and available to patients throughout the pandemic
- Coped with a huge increase in demand in the early lockdown
- Delivered medicines to the shielded and vulnerable
- Provided key advise lines to patients (including open walk in access) thus reducing burdens on other the parts of the NHS (especially GPs)
- Provided a substantial uplift in flu vaccinations in the autumn
- Are freeing a significant number of GP appointments by the CPCS service which is now able to refer patients directly to pharmacies to deal with their minor ailments

A significant number of lessons can be learnt in terms of how community pharmacies and pharmacy staff were routinely left short of PPE, unable to access full medical records, subject to abuse, not risk assessed (on an individual or premises basis), not paid for undertaking self-isolation and often left unsupported.

However, the lessons will only be learnt and progress made if the APPG listens to the reality experienced by the profession with an open mind and with a genuine desire to make the profession inclusive and forward looking, with opportunities for all irrespective of any protected or unprotected characteristics. Around 50% of pharmacists classify as being BAME.

The key issues in addressing the terms of reference can be themed around 4 broad areas :

A/ Pressures on individual pharmacists and their teams including availability and wearing of PPE , failures around risk assessments and issues around Covid-19 track and trace.

B/ Pressures (including financial) on pharmacy business contractors – cancellation of large number of locum bookings and subsequent misuse of regulatory leeway to save money, denial of salary increases whilst paying dividends and failing to invest in protecting staff (who were increasingly facing abusive behaviour) by meaningfully engaging with the zero-tolerance campaign.

C/ Need for better regulatory support - including the need to address certain illegal activities (around RP regulations), poor management of the student registration exam (deferred due to poor longstanding oversight deficiencies in workplace placement) -

D/ The reforms need to be wide-ranging and ambitious (more inclusive and especially given the diversity of the whole profession) and should be driven by the lessons learnt from the Covid-19 pandemic of the value of pharmacists and pharmacies. The benefit to the public (and the wider NHS) of having easy access to a healthcare professional, a highly qualified clinician on the high street, was widely appreciated and acknowledged. The focus should now be to build resilience into the sector and this forms the basis of our overarching recommendation.

Overarching Recommendation

The Pandemic highlighted the value of the pharmacy network and especially the sheer value of having many pharmacies (and thus pharmacists) in a town rather than just one single pharmacy. The creation of local monopolies may be in the financial interest of large corporations BUT it is not in the National Interest and we must ensure the viability of the entire pharmacy network. To achieve this, there must be a fair quantum of funding and also a fair distribution of that funding especially for smaller independent pharmacies and employees working within pharmacies.

The following is based on the actual feedback and conversations with our members to whom we provide not only indemnity support, but also wider employment, professional and emotional support.

A/ Pressures faced by individual pharmacists and their teams during the pandemic, especially early in the first lockdown:

Individual pharmacists and their teams worked exceptionally hard to ensure that patients were well served. There is ample evidence of individuals and teams going that extra mile repeatedly for the benefit of those that were shielding or at high risk. It was these frontline patient facing pharmacists and their teams that are the unsung heroes of pharmacy.

Some pressures whilst being caused by the pandemic exposed longstanding structural deficiencies which have built up over the last decade. We think it is important to highlight how these deficiencies added to certain pressures such as lack of PPE or failure to carry out risk assessments which, given the demographics of pharmacy, were especially important.

1. **PPE.**

1.1 Whilst we appreciate that there was a UK-wide shortage of PPE in all settings and difficult decisions had to be made for the allocation and use of PPE, we came across significant levels of poor practice.
1.2 Assertions by a PHE spokesperson at an NHS E webinar that the use of surgical masks to provide protection where social distancing was not possible did not apply to pharmacy staff working in cramped dispensaries.
1.3 Many pharmacies having to source and buy their own PPE at considerable cost.
1.4 Evidence of corporate pharmacy owners restricting the wearing of PPE even when social distancing could not be observed (as is the case in the majority of pharmacies), including locum pharmacists being instructed NOT to wear PPE even when they had provided PPE for themselves.
1.5 Evidence of other locum pharmacists being forbidden to use PPE provided to pharmacies and they were told to purchase their own. (A recent high court case confirms this was wrong: https://www.the-pda.org/high-court-legal-victory-strengthens-health-and-safety-rights-for-locum-pharmacists/
1.6 Lack of visors and screens to reduce infections and limit the spread of Covid-19.

2. **Risk-assessments**

2.1 Evidence of failure by corporate pharmacy owners to carry out risk assessments of premises or of staff (over 50% of pharmacists are of BAME origin).
2.2 Failure by many corporate owners to put into place physical constraints of entry to pharmacies to enable social distancing.
2.3 Failure by corporate owners to ensure that patients/customers wore face coverings (lack of clear signage and a general indifference by corporate Head Offices towards staff welfare and safety).

2.4 Failure to report to RIDDOR about incidents where staff may have been exposed to Covid-19 in the workplace. The regulator was ultimately forced to issue guidance regarding this. https://www.the-pda.org/pda-formal-letter-to-gphc-riddor/

3. Testing , track and trace :

3.1 Inconsistent messaging around self-isolation when contacted by track and trace made it especially difficult for pharmacists to follow correct advice.
3.2 Some organisations advising that when contacted by track & trace, staff must NOT give names of colleagues but only give the name of the pharmacy. This is so that track and trace cannot contact colleagues which would then oblige staff to self-isolate.
3.3 Exceptionally poorly worded guidance from certain pharmacy organisations which obfuscated what should have been a clear and consistent messaging around what constitutes close contact and thus the need to self-isolate.

B/ Impact on pharmacy businesses and a divergence of reaction :

The whole community pharmacy sector has faced a challenging financial climate due to year on year cuts to funding. The sector thus faced a perfect storm with the impact of Covid-19.

Already operating at near full capacity and with little slack, the extra workload spike in the early stages of the pandemic overwhelmed many businesses and the pharmacists they employ. Pharmacists reported working in pharmacy and at home, often unpaid, every day in order to keep the services from collapsing. Despite many smaller pharmacies operating under the threat of soon becoming unviable and the possibility of having to close, they still carried on throughout the pandemic to support their local communities.

However, during this emergency, we saw a clear divergence in behaviours. Many contractors, especially those that were family owned, typically behaved exceptionally well towards their staff, and they looked after them like their extended family. However, some larger corporate contractors focused on mitigating any financial loss.

We highlight the following key areas where divergence was seen most obviously :

4. Misuse of regulatory leeway :

4.1 The need to urgently self-isolate (or other urgent unforeseen circumstances) left some pharmacies without a pharmacist to supervise the dispensing or supply of medicines. The regulator allowed a specific time-limited dispensation where ready assembled medicines could still be collected by patients. Some corporate owners attempted to use this leeway to circumvent the legal requirement that every pharmacy should have a responsible pharmacist present.
4.2 There was a sustained and vociferous campaign attempting to suggest a difficulty in obtaining locum cover for these corporate pharmacies.

4.3 At the same time, we received significant anecdotal evidence (from our membership feedback) that corporate owners cancelled en-masse large number of pharmacist locum shifts and then used this as an excuse to operate pharmacies illegally without a responsible pharmacist.
4.4 Some anecdotal evidence of an attempt to reduce locum rates paid during the pandemic https://www.the-pda.org/c19-update-13/

5. Encouragement and inducements to break the law :

5.1 Our call teams handled numerous calls asking for advise on corporate owners making it a condition of allocating new locum shifts that locums undertook to (illegally) supervise more than one premises remotely. This had the potential for serious patient harm.
5.2 Failure to agree to this illegal "term and condition" would lead to not being booked in future.
5.3 Patient safety was placed at risk by some large corporate owners seeking to operate a pharmacy in a pandemic situation in the absence of the pharmacist.

6. Lack of leadership on zero-tolerance of abusive behaviours :

6.1 There has been a concerted effort supporting zero tolerance of abuse across the NHS to support staff when faced with abusive patients.
6.2 Abuse in community pharmacy reached record levels during the pandemic lockdown: https://www.itv.com/news/2020-04-09/pharmacies-abandoned-on-the-front-line-in-covid-19-effort-itv-news-survey-reveals
6.3 Some corporate pharmacy owners failed to meaningfully prevent the abuse experienced, though after increased pressure from the PDA campaign which was increasingly supported by law enforcement across the UK, all contractor representative bodies have now publicly stated they will support such an approach.

C/ Impact of inadequate regulatory support :

The pandemic should have been an opportunity for the regulator to show leadership and ensure that the public was not exposed to extra risks :

7. Regulatory leadership :

7.1 The regulator initially did not provide sufficient clarity and forcefulness in guidance to stamp out unethical or illegal activities especially around the operating of a pharmacy without a pharmacist (i.e. the Responsible Pharmacist Regulations)
7.2 Robust and more timely interventions may have prevented many of the abuses detailed above such as the obligation to carry out staff risk assessments.
7.3 The system of regulation and its ineffectiveness on the behaviour of pharmacy owners should have been more robust.

7.4 The PDA have consistently called for regulatory attention placed on contractors/owners to match that which is directed at individual practitioners.

8. Pharmacy Student and Trainee Welfare :

8.1 The pandemic exposed the inequalities faced by students, especially BAME students and overseas students during their 4 year MPharm and subsequent Pre-Registration year.

8.2 The Covid-19 pandemic disrupted all education institutions and hit hard students who were nearing the point of registration into their chosen profession. Pharmacy, unlike medicine could not allow these "pre-registration" students to enter the professional register until and unless they completed the "pre-registration" examination. This highlights the need to review the course structure.

8.3 In Northern Ireland, pre-registration exams were delayed, but subsequently held after a short delay, However, in Britain pre-registration trainees have been given status of Provisionally registered pharmacists, allowed to practice under increased supervision and still await their exam which will be held on-line for the first time and in early 2021.

8.4 Provisionally Registered Pharmacists are playing a critical part of the pandemic response and will be contributing to the vaccination process, but those who fail the exam in the new year will be immediately removed from the register and as a consequence also lose their employment immediately.

D/ Five key areas of reform and support needed to build resilience into the community pharmacy network.

We have listed a number of behaviours above. The pandemic did not cause many of them, but it did highlight the structural deficiencies that led to them being exposed during the pandemic.

We have to do better and to do better we have to first acknowledge what did not go well. Pharmacists respect their duty of candour and honesty and integrity are more important than face saving and fumbling if we are to learn the lessons that need to be learnt and meaningful change to ensue.

In the following section we highlight key structural changes that should be urgently put into place as part of an effective "lessons learnt" package of measures. Our focus below is on broader professional issues which if progressed will deliver real value for patients and fulfill the wider agenda of embedding resilience within NHS primary care.

i. Effective regulation – especially of pharmacy premises

At the heart of public protection lies effective regulation. Creating a culture where patient safety, professional independence and all the processes that lead to good healthcare has to be led by an effective regulator that is fit for purpose. We need to put the heart back into regulation where professional integrity and public mindedness are the values that drive professional behaviours.

In the context of pharmacy, and especially in the context of regulating large multinational corporations that dominate the UK pharmacy landscape this is especially difficult. Within primary care it is only opticians that face a similar situation, where multinational corporations are seemingly too large for a small British regulator to challenge. Dentists and doctors usually hold patient lists and work to a large extent as self-employed practitioners.

It is beyond the scope of this submission to discuss in depth the changes needed, but change is needed and it needs to be structural change backed by legislation with meaningful sanctions when public protection is at risk. Regulation of pharmacy owners needs to be as stringent as on the pharmacy professionals, as in practice their decisions and actions can have as much, if not more, impact on patient safety. Some of the issues we highlighted earlier could only occur in the void of effective sanctions.

ii. Meaningful integration of community pharmacy in primary care networks

Primary care within the NHS has undergone many reconfigurations. The last manifestation resulted in the forming of clusters of GP practices known as Primary Care Networks (PCNs). Many of these PCNs have received funding for their own pharmacists but the integration needed with local community pharmacies has not been embedded into the system.

To make the biggest gains in a joined up and integrated primary care network would be to ensure that community pharmacies, which derive over 90% of their income from NHS activities, become an extended but integral part of these networks.

The details are complex and outside the scope of this submission. However as we saw during the pandemic, it was only community pharmacies that were freely available to the public to access for advice and help whilst GP surgeries remained open but only for booked appointments and even then not face to face (unless essential)

The benefits of this “open without appointment” access for advice and relieving pressure pinches on the wider NHS was critical during the pandemic. We must learn and embed this into any future reforms.

iii. Full access to patient records with read/write functionality including fully electronic hospital discharge records shared with community pharmacy.

During the pandemic, one of the challenges that many patients faced was the need for emergency supplies of medicines. To safely provide these needs full patient record access. In simple cases, pharmacists can safely provide a small quantity of medicines until a prescription can be arranged. In more complex situations or where many medications are needed, it is essential to have some clinical history. During lockdown, many patients accessed pharmacies that were local to them rather than their usual pharmacy (say near work or near their hometown).

Pharmacies have limited access to what is known as a Summary Care Record (SCR), and whilst this may be adequate for simple supplies , for more complex cases it is not. Patients have to be referred to 111 or walk in centres where a doctor can access the full patient record.

The SCR has been useful, but full patient record access could be transformative for patient care and would have been really useful for patients during the pandemic.

iv. Removal of prescription charges and restrictions on prescribing items like paracetamol for the poorest patients.

The pandemic highlighted the extent of patients that are caught between having a low income and not being eligible for benefits and being able to afford their prescription medicines. We have come across cases where patients are making choices between medicines and leaving some which are essential but cannot be afforded.

The real impact of omitting some of these medicines is only realised when the patient needs more intensive treatment. For example, many patients will omit a PPI stomach protector when taking a strong anti-inflammatory medicine which then ultimately may lead to longer term complications and cost the NHS more.

Similarly, we have seen patients who are making choices between a meal and having to purchase paracetamol and massage balms for their osteo-arthritis.

The impact is felt by the poorest in our communities. The recent blanket ban on prescribing many basic purchasable products saved the NHS a paltry £30 million in a NHS budget of £100 billion plus.

v. Wider understanding of the role of pharmacists and the status of community pharmacy

We understand that “Doctors and Nurses” is often used as a common shorthand for health professionals, but throughout this pandemic pharmacists, and in particular community pharmacists, have often been forgotten heroes. The front door of the pharmacy remained

open whilst many other healthcare locations were closed entirely or at least had heavily restricted access.

Community pharmacists have often been treated as being outside of the NHS, while GP practice staff (which often includes other pharmacists) have been considered as inside the NHS system. We understand the high regard the country's GP population are rightly given, and indeed many employ pharmacists in their practice.

However, while GP practices and community pharmacies actually have a similar contractual status, community pharmacy is often treated very differently. Each may generate the majority of their income from NHS contracts and even have NHS branding on their premises, but they normally also generate income from other sources and are run for profit.

For pharmacists this manifested on various occasions during the pandemic, including pharmacists initially being excluded from the coronavirus compensation scheme should their work lead to their death, and in the treasury decisions to merely provide the sector with advance of funds which were already due rather than increase funding to what became the frontline of public access to the NHS.

The community pharmacy is an integral part of the NHS frontline. Its true value was seen by the unswerving efforts put in by pharmacists and their teams into ensuring that their doors remained open so that they could serve their local communities during this challenging period. GPs , NHS leaders and Government Ministers have all acknowledged the critical role played by pharmacists throughout the pandemic. Let us ensure that this is not now lost.

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