October 2022

Initial response to the UK Commission on the Future of Pharmacy Professional Leadership

pda
the pharmacists' defence association

| representing **your** interests |

Contents

About the PDA 2

The origins of the PDA's response 3

Recommendations 4

The work of the Commission 5

Leadership in Pharmacy 6

Appropriate undergraduate and postgraduate education of pharmacists 7

Establishing a Royal College of Pharmacists 10

How should professional leadership be delivered in the future? 12

Establishing a new Leadership Body 15

Conclusion 15

Annex 16

1. About the PDA

The Pharmacists' Defence Association (PDA) is the largest UK-wide pharmacist-only body, with current membership of more than 35,000 members and continuing to grow (15%+ in last two years alone).

Representing members in all sectors of the profession, membership is comprised of thousands of frontline locum and employed pharmacists working in each of the four countries of the UK to include the National Health Service, primarily in hospital pharmacy, in GP practice and primary care pharmacy, in community pharmacy and also in other areas of practice to include the prison service, the military, academia, organisations, science, research and development, clinical trials and the pharmaceutical industry.

Elected representatives make up its membership committees and networks, enabling the PDA to provide detailed sector specialist input into a wider range of consultations.

Over and above the sectoral representation, the PDA also operates four thriving equality and diversity networks enabling the wider membership to decide whether they want to join as a direct constituent or as an ally. These are BAME, LGBT, Ability and the National Association of Women pharmacists.

With thousands of active members, these PDA networks not only organise educational events for their respective members, but they also make authoritative contributions to any important policy or wider consultation response exercises.

As well as being a defence association and therefore directly concerned about the safety of patients, the PDA also operates as a trade union and in that regard, it has an important leadership role regarding the activities and roles that pharmacists are involved in and the environments in which these are delivered. Certified by the trade union regulator as being independent of the control of any employer (including the NHS) the PDA is currently the 21st largest of all UK trade unions. It is the largest pharmacists only representative body in Europe and according to the FIP (International Pharmaceutical Federation), is one of the largest exclusively pharmacist only representative organisations in the world.

PDA is also affiliated to the General Federation of Trade Unions (GFTU), the Irish Congress of Trade Unions (ICTU) and the Scottish Trade Union Congress (STUC).

The PDA is a member of the Employed Pharmacists of Europe (EPhEU) federation where the PDA chairman currently holds the Secretary General position. In October, the PDA was admitted to full membership of the International Federation of Pharmacists (FIP) where it now represents the interests of its UK member pharmacists.

PDA is the largest financial contributor to the profession's charity in Great Britain, Pharmacist Support, through its donations of £1 per member per year, since 2018 the PDA has already contributed more than £180,000 to this important cause.

2. The origins of the PDA's response

Most importantly and of significance to the work of this commission, the PDA delivers more than 5,000 episodes of support to members who have found themselves in a critical incident situation each year. Support is provided when members face regulatory or criminal proceedings, employment disciplinary episodes, or in situations where patients seek compensation due to allegations of errors or omissions.

Whilst not all of these are directly connected to incidents that will impact upon patients, many of them will affect patient safety either directly or indirectly. This provides the PDA with a rich vein of up-to-date experiences and an understanding of risk, which continuously inform its policies and future strategy. Many of these cases involve circumstances where a patient may have been harmed by their medicines or other inefficiencies that are inherent in the system. More worrying however, are those episodes which are indicative of a more systemic deficit within the area of professional pharmacy policy and of particular concern, those that involve poor leadership or deficiency in training and/or regulation.

The proposals put into this response to the current commission on pharmacy leadership are largely built upon this powerful catalogue of experiences and the lessons that should be learned. They are overlaid onto the current challenges facing the healthcare system and the opportunities that these create for pharmacy. They are also reliant upon the views of pharmacists working in a wide range of settings, gathered through recent surveys as well as many historical contributions made by members over the years. Surveys of PDA members indicate that many of them relish the prospect of being able to take greater clinical responsibility for their patients. Many have highly ambitious and creative aspirations for providing vastly superior and much more clinical services to patients than they are able to currently. These aspirations if harnessed properly could go a long way in assisting with the significant challenges faced by healthcare and wider society in the short and the long term. However, these pharmacists will need to be able to practice with the support of a much more appropriate post-graduate educational system and with much stronger unified pharmacy leadership than is currently the case.

Some members of the PDA find it greatly concerning that their sector of practice no longer receives the attention that it deserves by its professional leadership, particularly those working in the areas of science and pharmaceutical industry. They consider the current professional leadership and regulatory arrangements to be remote and therefore irrelevant; such concerns are ultimately to the detriment of the profession and the public.

The proposals put in this submission build strongly upon the views gathered from members but most importantly upon the cause-and-effect lessons learned by the PDA through its extensive experience of defending pharmacists when things have gone wrong

Recommendations

1. As with a programme of any change, the engagement of the people affected is an important step achieving the overall objective. The commission must work harder to ensure that there is significantly wider engagement around possible developments which affect more than 90,000 pharmacists and pharmacy technicians. Consideration should be given to take more time over these important deliberations.

2. Although the overall objectives of the commission are not yet widely understood, the PDA believes that there are two key aspects which must be addressed.

   a. Leadership which ensures that the skills of pharmacists are applied to best effect both currently and in the future.

   and,

   b. Appropriate undergraduate and postgraduate education of pharmacists.

3. **Creating a Royal College of Pharmacists**
   A Royal College of Pharmacists should be established and be responsible for the stewardship of the training and formation of practitioners in pharmacy. This would involve both undergraduate and postgraduate education. In this way it can play an important leadership, advocacy and standards setting role to support the development of pharmacy practice. Part of its role would be to manage risk and to support the safety of patients. It will be important for it to establish the distinct scope of practice for pharmacists and pharmacy technicians ensuring that they can work towards a common purpose. This will support their discrete areas of activity and ensure that they are working in a complimentary and symbiotic way. This is a role for the Royal College and not the government.

4. The Royal College of Pharmacists would take its place within the current framework of Royal Colleges; a federated model of expertise and one which ensures co-operation and collaboration with the other Royal Colleges that are involved in supporting the care of patients. Additionally, it would maintain powerful links with those organisations supporting science and innovation in medicines.

5. Whilst the stewardship role for education and training would sit with the Royal College, the role of accreditation and the development of the assurance framework should remain with the pharmacy regulators as it is they who have the regulatory authority in this area and their role is always to primarily act in the public interest.

6. It should not be for the government to determine the future of postgraduate pharmacy education, as it sought to do by the creation of the Postgraduate Medical Education and Training Board for doctors. This role should be undertaken by the Royal College of Pharmacists.

7. With a focus on the stewardship of education and formation of practitioners and the leadership, advocacy and standards development that is directly associated with these, the Royal College of Pharmacists would improve its chances of delivering this vitally important professional leadership role successfully. The added benefit would be that it could be supported through a much lower membership fee for pharmacists than would be the case if the Royal College had an extensive and more comprehensive brief.

8. **Creating a new pharmacy leadership body**
   With the emergence of distributed leadership in pharmacy, no one body in pharmacy can or should claim to be THE leadership body. The PDA supports the idea of a distributed leadership role in pharmacy with the established credible organisations in pharmacy working more collaboratively to deliver this role through the creation of a new pharmacy leadership body, which is distinct from the Royal College but which would involve it as a key stakeholder where appropriate. In this way, a mechanism could be found that enables the profession to speak with one voice on common agenda issues on behalf of all pharmacists, whilst also still allowing effective representation of more specialist niche issues. Within this mechanism, a quality assurance system which protects the image of the profession from well-meaning but amateur volunteer initiatives should be implemented.

3. The work of the Commission

From feedback that the PDA received from its members, and from added remarks made by many hundreds of pharmacists who have responded to a survey undertaken by Communications International Group, there are significant and valid concerns about the mandate, scope and make-up of the commission which will ultimately be making recommendations around the future of professional leadership for pharmacists.

Whilst some of the remarks received have been sceptical about the make-up of the commission or the process being undertaken, the quantum of responses received indicate that there is much more work to be done around building the credibility and purpose of the commission as well as engaging a far greater number of frontline pharmacists in having a say around professional leadership before the initiative can secure legitimacy and credibility.

In reality, the four government Chief Pharmaceutical Officers (CPhOs) unilaterally decided to launch a commission and it commenced without first engaging the profession on its purpose or scope. The CPhOs have selected the members of the commission, will function as advisors to the commission, will take part in the commission's meetings and will be the recipients of the commission's recommendations in a final report to be presented to them in December 2022

The four CPhOs are the most senior pharmacists within the NHS, which is the largest employer of pharmacists in the UK. The CPhOs are also the most senior government-employed pharmacists in which role they advise ministers. The work of the commission must therefore be seen within the significant limits of that context.

Nevertheless, the PDA supports the notion that the current issues regarding professional leadership need to be resolved, but believes this must be done in an inclusive manner, with significant engagement from the profession, from pharmacy technicians and from other legitimate stakeholders. The disappointing level of responses to the commission's initial survey and low levels of attendance at webinars demonstrate that much more work on engagement is needed as otherwise the result of the commission will fail to secure the hearts and minds of pharmacists. The PDA believe that an earlier phase of raising awareness of the need for a commission and a more relevant and transparent process of appointments to the commission would have been sensible and would have removed some of the potential hurdles in the way. In any event, producing the right recommendations is only part of what is required; leadership depends on the existence of "followers" and a revised landscape of professional leadership needs to have the support of the profession if it is meant to lead.

In terms of the survey undertaken by the commission itself, the feedback received by the PDA was that the ambiguous nature of the questions were indicative of a commission which was either not entirely sure of its own objectives or that it was not yet comfortable with the objectives that someone had set. The terms used within the survey will be unlikely to have delivered a consistent response, given the different ways in which some questions may have been interpreted by respondents.

That the commission has set a very short time frame for the completion of such an important undertaking was a mistake in our view. The commissions own survey had responses from less than 2% of pharmacists and less than 1% of pharmacy technicians (1019 pharmacists and pharmacy organisations and only 224 pharmacy technicians) and are not demonstrative of anything like the levels of member engagement that would be appropriate for such an important piece of work. The handful of webinars that the Commission has run add very little to the statistics. It leads the PDA to ask an obvious question; If, as is widely felt, the problems with pharmacy professional leadership have emerged since the split of the RPSGB in 2011, then why do the proposals for change need to be finalised within 6 months? The approach that has been taken appears to break the well-established rules on successful change management.

The commission must work harder to ensure that a far greater engagement of those who will be affected by the outcome around the future of professional leadership in pharmacy. Greater transparency and engagement with the profession is of paramount importance. The PDA calls for the need for a serious review in this regard, given the importance of the potential outcome, currently, this work seems to be operating on the margins as far as most pharmacists are concerned.

The PDA has considered its response to the Commission's call for evidence and has taken into account the answers to **questions that were raised by its members to the four Chief Pharmaceutical Officers and Co-Chairs.** Couched within the framework of the

concerns already expressed and also the fact that the commissions survey was limited in its scope, the PDA has developed some wider themes that it believes should be considered by the commission.

4. Leadership in Pharmacy

Today, medicines are the most common clinical intervention made by doctors and the cost of medicines represents around 13.5% of the entire NHS budget. After salaries, this is the second largest NHS budget item. When medicines are used correctly, they can alleviate the symptoms of chronic conditions and can successfully treat acute conditions. However, when they are not used correctly or are not managed properly, or if prescribed in the wrong combinations they can fail to alleviate symptoms or cure patients and, in many situations, they can actually cause harm and place an unnecessary burden upon the NHS.

Research has shown (DoH policy research programme) that each year £750 million of medicines are not taken as required and they are unlikely to be working properly or at all because of this poor compliance. Additionally, a further £300 million of medicines are simply wasted each year (York and London waste report); perhaps because they are unnecessary. Worse still, around 7% of hospital beds are occupied by patients who have been harmed by their medicines due to Adverse Drug Reactions (NICE). In many instances, this occurs even though they have been taking their medicines in accordance with their prescriber's intentions.

All of these matters point to a powerful conclusion; The use of medicines in society is so important, that it deserves much more attention than hitherto has been the case. It is time for the system to be dramatically improved so that much more attention can be paid to helping patients use and manage their medicines effectively and safely; this is a discipline called Pharmaceutical Care.

Many pharmacists are working hard, but they have not been allowed to work smart. As the experts in medicines, their deployment across large parts of the healthcare system has thus far been hampered by a lack of focus upon these unique skills and a lack of collaborative working opportunities especially with colleagues in other sectors. More recently, as pharmacy policy has started to become more devolved, the green shoots of a more ambitious pharmaceutical care developmental agenda has become more evident. However, in a lot of instances, pharmacists are let down and progress is hampered due to poor pharmacy leadership and a lack of a joined-up plan for both undergraduate and postgraduate education.

With the emergence of the newly qualified Independent Prescribing practitioner pharmacists just a few short years away, there has never been a more critical need to address many of these problems. It is vital that this is done within a framework that has the safety of patients and the appropriate competence of practitioners embedded at is very core; added to this is a consideration of the most appropriate working practices. The imperative to deliver much stronger pharmacy leadership and to connect this with an undergraduate and post-graduate training infrastructure for pharmacists that is fit for the much more ambitious purpose of supporting the future of pharmacy practice has never been more apparent. The timing of the pharmacy leadership commission is apposite.

We believe that there are two principal components that need to be in place to ensure a future in which patients and other stakeholders achieve the maximum benefits of the skills and expertise of pharmacists and that pharmacists in delivering this can grow in their job satisfaction and professional fulfilment and these are:

- **Leadership which ensures that the skills of pharmacists are applied to best effect both currently and in the future.**

  and,

- **Appropriate undergraduate and postgraduate education of pharmacists.**

We deal with these two issues substantively starting with the education issue.

Pharmacists are working not just within primary and secondary care within the National Health Service or the private sector, but also in other sectors such as industry, science, research, academia and other important areas. Pharmacy leadership must ensure that pharmacists will not only deliver the direct healthcare needs of patients, but that pharmacists can support the more nuanced, but critically important medicines related developmental requirements of society. This becomes much more important as developments such as personalised medicines and gene therapy confer their benefits upon society.

It is important to ensure that the two core components described above can be delivered across a dispersed area of activity, what the PDA would call the wider pharmacy ecosystem. The current 'professional leadership' exercise must not simply be seen through the lens of the narrower needs of the NHS and its contractors.

Appropriate undergraduate and postgraduate education of pharmacists

Undergraduate training

Historically, the undergraduate courses for pharmacists have been developed by the individual schools of pharmacy. These have been designed through a process which on the one hand enables a pharmacy school to develop a programme styled along the lines of its preferences and ambitions (be that more of a clinical, a specific primary care or even a science-based approach), whilst on the other hand, requiring them to fulfil ubiquitous standards placed upon them by the pharmacy regulator and satisfy the regulators detailed accreditation process.

In the past, when the Royal Pharmaceutical Society of Great Britain was both the regulator of pharmacy and the professional leadership body (prior to 2010), the disparate sectoral voices of the profession used to have a much greater influence within its operations. RPSGB elected Council members came from many of the professions sectors. Further expertise was delivered through specialist groups such as the industrial pharmacists' group, and a historically close link with the Academy of Pharmaceutical Sciences. Routinely, elected representatives of science or the industry used to hold senior positions at RPSGB officer level. In addition, a senior scientist was always to be found on the executive board of the RPSGB.

Collectively, they acted proactively and with considerable enthusiasm to ensure that the important components of science, research and industry where never far from the fore-front of professional considerations being made by the RPSGB.

These factors inevitably had a significant influence over the content of the ubiquitous standards of the (RPSGB) regulator, in so far as they were applied to the accreditation of the undergraduate pharmacy courses.

This meant that newly qualifying pharmacists upon completion of their pharmacy undergraduate courses had a range of mainstream career options to pursue, those in community or hospital and after the mid 90's primary care pharmacy, but also pharmaceutical industry, research and development and science. The courses were more reflective of the wider roles of pharmacists across the profession's many sectors, and this was ultimately in the interests of wider society; especially since it enabled pharmacy to have an influence in the research, design, development and manufacture of medicines.

However, when the RPSGB was required by the government to cede its regulatory function to the GPhC, the wider influence of the profession in the design of the undergraduate training courses became detached. As well as regulating pharmacists, the GPhC was given the role of accrediting the undergraduate course by the government and its council was appointed under the government's supervision. It no longer has a multitude of senior science, industry and research experts on its ruling council, no directors on its board responsible for science and no strong links with the Academy of Pharmaceutical Sciences.

The aforementioned proactive enthusiasm for science, research and industry and the impact of this upon the design of the undergraduate training courses has had perhaps unintended consequences.

With a much greater focus upon the areas deemed a priority by the NHS, (that of patient-facing practice) the undergraduate training courses have unsurprisingly narrowed in their focus and the newly qualifying pharmacist of today is crafted more in the image of the requirements of the NHS.

By one metric, that the undergraduate courses are now more broadly falling in line with the government's developmental and clinical NHS agenda by dint of a regulator accreditation process may well be deemed a big success by the government or the four Chief Pharmaceutical Officers of the past. However, it has often been stated by newly qualified pharmacists that the undergraduate courses need to provide a broader approach to training one that is much more relevant to their hopes and aspirations and that they are eager to learn about many and varied career options. Furthermore, employers in sectors, such as the pharmaceutical industry, science and in the important area of research and development of medicines are concerned that this more health service focussed pharmacy undergraduate course no longer supports their needs and as a consequence, they are no longer seen as mainstream career options by newly qualified pharmacists. The influence of pharmacy leadership in these important areas has consequently waned.

Other issues have also emerged. That the GPhC whilst meeting its stated objectives, is no longer directly involved in regulating pharmacy innovation has created a vacuum in the area of e-pharmacy.

The important lesson about unintended consequences is that sometimes, the excessive control that the government seeks to exert might enable it to develop its own agenda, but this may be done at the expense of the loss of a much bigger opportunity or an inability for the system to handle wider concerns. In the examples described above, not only did pharmacists have their scope of professional practice reduced, the influence and involvement of pharmacy in medicines research and development was diminished and in some instances innovation in the area of e-pharmacy was left unchecked, ultimately, wider society lost some important benefits.

Protecting the unique expertise of pharmacists for the benefit of the public is an important pharmacy leadership issue

Pharmacists are the only healthcare professionals for whom one of the most important distinct contributions to the wider multidisciplinary healthcare team is that they are the experts in medicines. The education and formation system must enable them to understand how medicines work and how to apply that expertise for the benefit of patients. This is especially the case as medicines become more personalised in the future through developments in gene therapy.

It will be vital to ensure that the commission on the future of pharmacy leadership does not exacerbate the problem of unintended consequences by the further pursuit of a government agenda which would benefit from the creation of pharmacists in the image of those required by the NHS. The four Chief Pharmaceutical Officers must not make the mistake of creating a new specific government established body for determining the future of postgraduate pharmacy education and therefore controlling this programme. Famously, the

government did so for the doctors when it created the Postgraduate Medical Education and Training Board. (Demystifying PMETB | The BMJ). This is particularly important in pharmacy since principled concerns about one of the governments current flagship programmes; the formation of Independent Prescribers at undergraduate level are already being expressed. Should a structured postgraduate training framework for pharmacy that is independent of government and one built on quality and patient safety foundations be put in place, then this will be an important additional patient safety measure. Resulting in a far greater chance of the IP programme for pharmacists being a success.

Post-graduate training

From a postgraduate training point of view, the profession has hitherto been served by an ever-wider range of training providers. These may involve the established academic institutions such as the schools of pharmacy on the one hand, through to the voluntary 'Sunday afternoon' volunteers who have banded together to call themselves an 'association' and which rely upon sponsorship deals from the pharmaceutical industry for their survival on the other.

In between these two extremes lie a range of other providers such as the various centres for postgraduate education across the UK which are government funded, the training departments of established pharmacy organisations that provide specific training to support their core members, employers that operate 'in house' training departments to train their own staff and in some instances, these might be opportunistic commercial for-profit training providers.

The deficiencies must be resolved

The PDA has on many occasions supported pharmacists through regulatory episodes, or in cases where allegations of negligence have been made by patients seeking compensation for damages or in cases where Coroner's Inquests have followed the death of patients. In a worryingly large proportion of these incidents, the principal failure of the pharmacist was that they relied upon deficient or in some instances dangerous training material or advice provided by unaccredited voluntary organisations that should never have been allowed to involve themselves in such a vital and influential activity.

This is particularly the case where they have been involved in the formation of pharmacist prescribers. In other instances, the PDA has seen government funded initiatives and training lacking in a number of important patient-safety based components. The initial waves of pharmacists working in GP practices commenced their activities on a poorly thought through government funded initiative in England which has been cited by numerous research institutions as being ill prepared and lacking in leadership. How could pharmacists, eager to learn more about their new, exciting chosen career development have known how deficient their training provider could possibly be and that they would be so ill equipped to practice safely that they would actually end up harming patients?

> **If the standards of training and education in schools, colleges and even children's nurseries are regulated by OFSTED, in recognition of the important formation role that they play, why is it that the formation of pharmacists, who these days are increasingly involved in patient facing roles can be charged fees by voluntary associations or commercial training providers whose material has on occasion been shown to be deficient and which is not accredited?**

Recently, the GPhC has started to consider the area of postgraduate education by creating a specific group called The Post Registration Assurance of Practice Advisory Group. Undoubtedly, this is an important first step which demonstrates that even the current regulator recognises that there are problems that must be resolved. However, the scope of their exercise is not (yet) looking at the accreditation of training providers.

5. Establishing a Royal College of Pharmacists

The PDA believes that a very powerful component of future professional leadership is the ability to support the correct training and formation of pharmacists at both undergraduate and post-graduate level. Additionally, in managing risk, it will be important to recognise the distinct scope of practice for pharmacists and pharmacy technicians towards a common purpose. So as to support the safety of patients, it will be important to recognise the distinct roles of both. This should not be a job left to the government. Like physicians, podiatrists, GPs, occupational therapists and others, the organisation that should take charge of this pivotal role in pharmacy, a role which underpins the entire future of practice should be a Royal College. The Royal College of Pharmacists should be responsible for the stewardship of the training and formation of pharmacists, amongst its objectives would be a focus upon patient safety and also the wider science and sectoral deficits described earlier.

The Royal College of Pharmacists would take its place within the current framework of Royal Colleges; a federated model of expertise and one which ensures co-operation and collaboration with the other Royal Colleges that are involved in supporting the care of patients. Additionally, it would maintain powerful links with those organisations supporting science and innovation in medicines.

With a distinct focus upon education, training and formation, the Royal College of Pharmacists would be in a strong position to advocate for professionally fulfilling future roles of the profession, additionally, it would be in a strong position to be able to prepare future practitioners for this future. It would also be able to develop as well as advance the standards of practice expected by the regulator.

Creating the requisite standards and requirements for both the undergraduate and postgraduate training courses in pharmacy, it should be the Royal College of Pharmacists and not the government through its pharmacy regulator that would determine the standards to be observed for the formation of pharmacists. Through the development of faculties, the Royal College of Pharmacists could also support the development of specialist practice in the long term and with it, a structured career framework for pharmacists. Not only could it set the standards for training and competency, but it could also provide training and examinations in its own right. In effect, this could reverse some of the perhaps unintended consequences that have resulted from the creation a government appointed regulator and the reduction in wider pharmacy influence in other sectors, enabling the profession of pharmacy to have a much bigger impact not just in healthcare delivery, but also in the important area of medicines.

The existing Regulators would still accredit the training.

Importantly, the role of accreditation and assurance of the training would still remain with the pharmacy regulators as it is they who have the regulatory authority in this area and their role is always to primarily act in the public interest. Additionally, if accreditation of training courses was given to the Royal College of Pharmacists, then this would preclude it from generating its own training programmes in the future because a range of conflicts would emerge. However, it would be the standards for training and formation set by the Royal College that would be the ones that the pharmacy regulators would then use to assure and accredit not only the undergraduate training courses but also, in future, any providers offering post-graduate training in areas of pharmacy practice which could have a direct impact upon patient safety. If the Royal College chose to provide training in the future or work in collaboration with others to do so, then these too, would have to operate to the standards that it had set.

Such an arrangement would support the public interest and be of benefit to pharmacists since the training and formation standards set in this way would;

- **Enable a return to the pharmacy undergraduate course being more enthusiastic for and able to support careers in a wider range of sectors; to include science and the pharmaceutical industry.**
- **Require postgraduate training courses performing to a consistent standard leading to improved safety for the public and greater confidence for pharmacists.**
- **Require postgraduate training providers to be competent and safe.**
- **Ensure that these standards applied to all providers, to include initiatives poorly thought out by government.**
- **With a focus on the stewardship of education and formation of practitioners and the leadership, advocacy and standards development that is directly associated with these, the Royal College of Pharmacists would improve its chances of delivering this vitally important professional leadership role successfully. The added benefit would be that it could be supported through a much lower membership fee for pharmacists than would be the case if the Royal College had an extensive and more comprehensive brief.**
- **Having the pivotal role in education would enable the Royal College of Pharmacists to be one of the important components of distributed leadership in pharmacy (see section 7).**

The objectives of the Royal College of Pharmacists may include

- Educating pharmacists at all levels of their careers and supporting them to fulfil their potential.
- Influencing the way that medicines and pharmaceutical care are designed and delivered.
- Advocating for and championing future roles and developing the supporting standards for pharmacists.
- Ensuring that the education and formation of pharmacists supported these future roles.
- Supporting future practice by anticipating future training needs of pharmacists and the pharmacy team.
- Through its formation of pharmacists, improving health and healthcare and leading the prevention of ill health across communities.
- Ensuring that patient safety was paramount to its deliberations.

6. How should professional leadership be delivered in the future?

Whilst in the previous section on education, the PDA has already made a case for establishing a Royal College of Pharmacists and has described its role in stewardship of education and formation of practitioners and the leadership, advocacy and standards development that is directly associated with these, this still raises the issue of wider leadership within the sector. Currently, it is often seen as weak and divided.

If this commission into future professional leadership is to create a structure that can advocate effectively for the interests of pharmacy and the public, then it must recognise that simply repeating the historic exercise of anointing one body with the name 'the professional leadership body' does not and will not make it a leadership body.

Prior to the split of the regulatory and membership functions of the RPSGB in 2010, the RPSGB could confidently claim to have all pharmacists in membership as they had to be its members to practice. In Northern Ireland, a similar leadership arrangement still exists, albeit through an independently operated Forum. The important lesson that must be learned after the split of the RPSGB in 2010 is that the RPS no longer enjoys a mandatory membership and its membership has fallen significantly. The RPS cannot be the leadership body if pharmacists choose not to follow it, neither can it seek to lead in additional new and ambitious areas of activity as has recently been described in its vision paper, if pharmacists are not satisfied that it has been able to demonstrate effective leadership in its current activities.

Finding a way to mandate all pharmacists to become members of the RPS; perhaps by some kind of a GPhC regulator authority handover is not the way forward. Such a move would not only go against the tide of reality (and therefore would inevitably fail), but any additional fees or regualtory requirements forced onto pharmacists by the outcome of the commission on pharmacy leadership would never be acceptable to pharmacists and would likely be resisted by numerous representative organisations.

Recognising distributed pharmacy leadership

Recognising the distributed leadership that is already available would be a more positive and pragmatic way

forward. In the pharmacy profession, pharmacists find themselves working in a very wide range of sectors and roles. Many of these are patient facing, but some are not and increasingly, pharmacists are choosing to work in portfolio careers.

Irrespective of which sector(s) pharmacists practice within, the ultimate priority must always be for patient safety and for confidence in the profession to be maintained. It is the role of the healthcare regulators to ensure that patients are protected and that is why the requirement for pharmacists to be registered with the GPhC and the PSNI is mandatory.

Beyond that however, the PDA believes that it is right for pharmacists to decide whom they would rely on and for what and in this way, distributed leadership in pharmacy has emerged.

In 2022, there are many pharmacy organisations representing the various sectors of practice and fulfilling a wide range of roles. Some of these are large, professionally run multi-million pound budget established bodies respected by their members and capable of providing a range of services that their members come to rely upon as a cornerstone of their practice. Some provide representation which is unique to their members. Some of the pharmacy organisations have separate and distinct roles, other organisations have roles which overlap with those provided elsewhere. Some have a mainstream role to play, whilst others have been specifically established to develop a specialist agenda. Other organisations however, are operated by volunteers in their own time and are made up of enthusiasts.

All of these organisations make up what the PDA would call the 'pharmacy eco-system'.

An important aspect of these 'pharmacy eco-system' organisations that the commission must consider is that membership is optional and this means that each organisation must earn the respect and the engagement of its "members" through what it offers and how it conducts itself. A further benefit is that in this way, leadership can also become reflective of the significant devolution of health policy to the four countries of the UK.

The significance of distributed leadership

With the emergence of distributed leadership in pharmacy it is evident that no one body in pharmacy can or should truly claim to be THE leadership body, neither does it have a monopoly on such a title or can it expect to dominate this space and it is reassuring to note that some of the four Chief Pharmaceutical Officers are already recognising this reality.

The interesting debacle between the stated intention of the RPS to absorb the educational needs of the pharmacy technicians was quite understandably met with a rebuke from the Association of Pharmacy Technicians (APTUK) and it would earn exactly the same reaction from other pharmacy organisations if it sought to take on roles and functions that are already delivered elsewhere. With a significantly changed pharmacy landscape, there will not be a return to the past and if pharmacy leadership is to be successful then it must adapt. In the 21st century pharmacy leadership and authority is distributed because of expertise, credibility, speciality, critical mass and many more factors besides; many of these being the criteria required by practicing pharmacists and these factors will increasingly distribute the leadership of the pharmacy profession in the future.

Building upon the existing 'pharmacy eco-system'

If as has been described, pharmacists are served by a wide range of organisations, then far from this more distributed leadership being seen as a weakness, it should be recognised, fashioned, built upon and turned into a strength if pharmacy leadership is to powerfully support the hopes and aspirations of pharmacists. A failure by this commission to recognise this, will merely continue the problems of the past.

There is a downside however, to this distributed leadership and it is here, that the PDA believes that the commission should invest its energy. Currently, whilst many of the existing sectors in pharmacy already have strong and well organised representative organisations, in some cases this leads to a multitude of sometimes competing voices as well as much in the way of duplication. As an example, in 2022, there will likely be five separate organisations developing or publishing their own future vision for pharmacy. This means that, important external stakeholders find it increasingly difficult to work out who it is that they should be listening to when seeking representations from the profession.

Much of this duplication saps the creative energy of the profession as pharmacists face a multitude of surveys, webinars and similar competing initiatives. It also fails to use the overall available financial resources of the various pharmacy organisations to best effect for the benefit of the profession.

Pharmacy also has more than its fair share of small 'volunteer' organisations and whilst they aim to draw attention to important issues, or have been able to make nuanced and expert contributions, they have occasionally demonstrated a worrying lack of competency and organisational expertise. Judging by the defence efforts invested by the PDA to defend pharmacists who have followed inappropriate advice, some of these organisations whilst well-meaning have either sought to involve themselves in areas where they have no expertise or, because they lack any proper infrastructure or governance, may actually be doing more harm than good. (Sadly, the same can also be said about some of their pharmacy training initiatives).

Any new leadership structure should create an arrangement that can rely upon the good things that the existing distributed leadership can deliver, whilst creating a quality structure that prevents the harmful effects of well meaning, but sometimes amateur contributions of the smaller 'voluntary organisations' being made. An attempt should be made to encourage the strong, well-resourced representative organisations to work within a much more unified and collaborative framework. An example of this is where independent airlines work collaboratively together creating a 'Star Alliance'. The result is that the airlines whilst still able to have distinct geographical areas in which they are dominant or where they will compete with each other, are able to work collaboratively with others in other areas to offer a dramatically improved service for all their collective passengers. If this concept were applied to pharmacy leadership, it could be used to present a shared position to the outside world on at least the common ground issues. Additionally, it could clarify which organisations would lead on which services for the benefit of the wider profession. This would be a big step forward.

The role of smaller 'volunteer organisations' in pharmacy leadership

For the protection of the profession's reputation an attempt must also be made by the commission to create a safe sub structure framework which can meet certain standards of probity and operational competence in which organisations run by volunteers can make their important contributions safely. In such a way, some of the more specialist and niche contributions can be fed into the overall leadership process.

One issue that it will be important for the commission to consider is legitimacy. It is vitally important to ensure that the small 'voluntary' organisations are part of the solution and not a part of the problem. For any such body its status, circumstances and capability needs to be transparent and it must achieve certain standards to ensure that it is fit for purpose.

Is it fit for purpose?

- How is it funded?
- Is it operated for profit?
- How many members does it have?
- Is it regulated, and by whom?
- What is its capacity and the competence of its staff?
- Can it guarantee continuity and demonstrate resilience?
- What is the quality and status of any "advice" it provides?
- Can its advice be relied upon and is it indemnified?

7. Establishing a new Leadership Body

In developing and taking advantage of the concept of distributed leadership it is proposed that a new and separate mechanism over and above the Royal College is established; through the creation of a new Leadership Body made up of the established credible pharmacy organisations working collaboratively to deliver this role.

In this way, such a new body would be able to coalesce around topics and issues with a common agenda and talk as with one voice on behalf of all pharmacists.

With pharmacists already recognising and voluntarily becoming members of a number of pharmacy organisations, they would automatically enjoy the benefits of such a collaborative structure.

This new structure could rely on a simple practical method enabling the established organisations to collaborate, one which would not involve their members in any additional costs. In so doing, it would be possible to utilise these existing organisations in the creation of an overall representative and wider leadership structure for pharmacists. Whilst it is recognised that there will be specific issues upon which agreement cannot be found, such a leadership structure could provide a powerful vehicle for issues which are of a common agenda.

For example, such common agenda items may include a collective future vision for the profession, responses to threats emerging from proposals on a range of government and other consultations. Matters could include challenges and opportunities for the profession, portfolio pharmacy careers, funding of community pharmacy, the future of the NHS and pharmacists roles within it, unwelcome interference in the profession by the government. Such arrangements would in some instances mean that there is only one single and powerful response on a matter by the profession, in others, there could be one central response, with nuances followed up by the specific individual organisations. Clearly, in some instances, there would be no single unified response; and this would merely reflect the current situation.

Such an arrangement could include joint representation from the Royal College of Pharmacists when deemed appropriate; indeed, such an arrangement exists on issues of joint concern between the Royal College of Physicians and the British Medical Association. Such a body would have representation from a number of established pharmacy bodies; the criteria for which could be established at the outset to ensure that the appropriate expertise and the required stability was available.

Within this mechanism, a quality assurance system which protects the image of the profession from well-meaning but amateur volunteer initiatives could be implemented.

A mechanism could then be created allowing these smaller 'voluntary bodies' to feed in their issues of concern.

8. Conclusion

The PDA wants to work with the commission to improve engagement and to listen to members to help build a set of proposals which has the buy-in of a majority of the profession before and after any detail is confirmed. The PDA makes these proposals as its initial response to the UK Commission on the future of pharmacy professional leadership. It advocates an arrangement where the issue of leadership in pharmacy (which as a necessity is underpinned by education) can be built upon solid foundations and managed to best effect for the benefit of the pharmacy profession, patients and the tax payer.

Annex

Confirming the scope of the Commission

There are two other very important dimensions of the commissions' work which need to be individually mentioned and addressed separately and these were issues that members have raised with the PDA. These are geographic scope and who is considered to be a pharmacy professional.

Geographical scope

There are multiple models for working across the complexities of the UK and different solutions can be appropriate for different countries.

The membership of the PDA is UK-wide and it works respectfully with peers in other jurisdictions. Some PDA members practise across borders, with for example portfolio careers that place them on either side of a national boundary for each role. Where this is between for example Wales and England, the PDA supports them in both areas, whereas if this is between the North and South in Ireland the PDAs coverage is restricted to UK.

- Some other bodies, such as the Pharmacy Schools Council, are also UK-wide.
- There are two pharmacy regulators in the UK. GPhC for England, Scotland and Wales, and PSNI for Northern Ireland.
- Some employers, such as BUPA or Boots, have operations across the UK.
- The NHS is devolved to each of the four home nations.
- Many bodies such as NICPLD, Community Pharmacy Scotland work exclusively within their own country.

Unlike the GPhC/RPS split, the professional body in Northern Ireland has not fully separated from the regulator.

The larger the geographical scope for a leadership body, and the more members, the greater the economies of scale, but its decisions are made further from front line practice. The commission, which includes the government CPhOs from all four countries, should consider if they believe Great Britain still needs a singular leadership body, or whether, more nuanced arrangements should be in place for each country. Importantly, it should not be the case that a pharmacy policy in a devolved country is controlled by England.

A further potential structure would be a UK-wide solution, however, if this model is considered it must be for the profession in Northern Ireland to decide if such a change should ever occur.

Other members of the pharmacy team

As a solely pharmacist organisation, the PDA speaks for pharmacists and does not have pharmacy technicians, dispensing assistants, drivers or other members of the pharmacy team in its membership. However, it fully appreciates that they are all valued colleagues who work alongside its members every day; they are often the friends, family and the fellow employees working together as a team.

Similarly, APTUK has Pharmacy Technicians in membership and does not speak for those in other roles. The PDA has continually called out the use of the generic term "pharmacy professionals" as a cause of confusion in the view of patients and others regarding the respective aspects of professional and technical roles.

The Commissioners have told the PDA that they consider "Pharmacy professionals" to be "registered pharmacists and pharmacy technicians." Pharmacists across the UK and pharmacy technicians in Great Britain meet that criteria.

In 2019, the PDA published a detailed report entitled: **Pharmacy technicians: an assessment of the current UK landscape**, and proposals to develop community pharmacist and pharmacy technician roles and skill mix to meet the needs of the public.

We believe the report is essential reading for members of the commission when considering the pharmacy technician role and how it fits into any leadership arrangements. In the report, the PDA makes various recommendations and describes a way forward which could be embraced to:

- Unify pharmacists and pharmacy technicians behind a common vision and purpose, based on shared interests and mutual benefit.
- Develop more rewarding, fulfilling roles for both groups, including enhanced clinical roles, which make more appropriate use of their respective skills.
- Establish a symbiotic, complementary and effective skill mix model in community pharmacy.
- Create rewarding career frameworks, supported by skills and salary escalators and appropriate remuneration.
- Enhance patient care and safety, improve governance and regulation, develop the UK healthcare infrastructure and reduce the burden both on community pharmacy and other areas of the NHS such as GP surgeries and secondary care.

Grandparenting of pharmacy technicians

One significant concern raised in the report was that 73% of those on the register of pharmacy technicians (as at April, 2017) had been admitted onto the register through 'grandparenting' arrangements, and the GPhC held no records of any assessments having been conducted as to the suitability of the qualifications which were relied upon during the grandparenting process.

Though this figure has since reduced to 53% (at 31 March 2022) of registrant pharmacy technicians, the above still applies for the majority of the pharmacy technician workforce in Great Britain. There is also a material difference between the role of pharmacy technicians in hospital and in community pharmacy and a risk in treating these two very different populations as a homogenous group.

It is certainly not for any existing pharmacist leadership body to decide it is to absorb responsibility for Pharmacy Technicians. It must be for those in the pharmacy technician role to collectively determine which bodies they need and would like to join, in the sector in which they work, and across all sectors where pharmacy technicians are employed.

Should a recommendation be to widen membership of any existing pharmacist organisation to membership of pharmacy technicians or any other members of the pharmacy team. Even if the leadership of that organisation were inclined to follow that recommendation, then the PDA would expect that the organisation would have to ask its current members for a collective decision on the proposal.