Supplementary written evidence submitted by The Pharmacists' Defence Association (PHA0074)

1. Introduction

1.1 The Pharmacists' Defence Association (PDA) thanks the Health and Social Care Committee for the opportunity to provide evidence during a public session relating to their inquiry into pharmacy on 16th January 2024. The appearance was the first time the Committee has ever heard from the representative of front line employed and locum pharmacists working across all areas of practice in the UK, the PDA represents over 37,000 members.

1.2 In addition to the written evidence[1] submitted in July 2023, the PDA would like to recap on the points made during the session and highlight a small number of emerging but highly significant matters of relevance to the inquiry that time did not permit to cover.

1.3 The session was focussed on workforce, and therefore this is the first area to address.

2. Workforce

2.1. As highlighted through the public sessions of the inquiry so far and across all areas where pharmacists work, there are workforce challenges in pharmacy. Consistently, pharmacists tell the PDA in significant numbers about their lived experiences in the workplace, and what influences their decisions about where they work and how conditions impact on their health and well-being. These include chronic understaffing, sub-standard working environments, an absence of protected training time and experiences of racism[2], violence and abuse[3].

2.2. The Pharmacy Workforce Race Equality Standard (PWRES)[4] report published by NHS England in September 2023 highlighted experiences of the NHS employed pharmacy workforce in 2022.

"*In terms of staff experience, it shows that pharmacy team members of Black, Asian and minority ethnic origin experience more harassment, bullying and abuse, poorer career progression and greater experience of discrimination than White pharmacy team members. It also highlights that pharmacy team members of Black ethnic origin are least likely to feel their trust provides equal opportunities for career progression or promotion, and that Black, Asian and minority ethnic female pharmacy team members report the most personal discrimination at work*".

2.3. In specific feedback from hospital pharmacists to the PDA on workforce related issues, around 77% of respondents were looking to change their career or employment status in the next 12-18 months.

- The primary concern was pressure and mental health concerns (29%) and pay (28%).

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[1] committees.parliament.uk/writtenevidence/122358/pdf/

[2] Pharmacist racially harassed by pharmacy team members – UPDATED WITH FULL TRIBUNAL JUDGMENT | The Pharmacists' Defence Association (the-pda.org)

[3] PDA highlights ongoing concerns about increasing levels of violence and abuse in community pharmacy | The Pharmacists' Defence Association (the-pda.org)

[4] NHS England » Pharmacy Workforce Race Equality Standard report

- Other themes were concerns around burnout, workplace pressure (not enough resources, skill mix) and dissatisfaction (lack of reward, feeling undervalued and demotivated).
- Around 4% of respondents cited bullying and harassment as their primary concern.

2.4. A PDA workforce temperature check of over 2,000 pharmacists working in all areas of practice in December 2023 found;

- 30% of respondents were looking to change their employment status/job within the next 18 months and nearly 1/3 of those were looking to leave pharmacy altogether.
- Approximately 2/3 of all respondents are required to undertake more non-clinical work due to lack of support staffing.
- This is consistent with the annual community pharmacy survey data[5] (England) which show a significant reduction in trained support staffing levels which coincides with reductions in funding for the community pharmacy contract over the last five years.

2.5. Set against funding challenges and reductions in support staff, PDA members tell us that the substantial increases in service provision have contributed significantly to workplace pressure and burn out.

2.6. Examples of the scale of workload in community pharmacy in England alone include;

- In 2022, PSNC (now CPE) suggested that there were around 1.2 million informal consultations taking place in community pharmacies in England every week[6].
- The uptake in community pharmacy vaccination programmes for flu and Covid-19 is increasing (there was a 3.2% increase in flu vaccinations in England in 2022/23 compared to the previous year, with 5,007,578 vaccinations administered by the end of March 2023[7]).
- The Community Pharmacy Consultation Service (is now part of the wider Pharmacy First Service which is predicted to reduce between 10 and 30 million GP appointments) and the recently introduced hypertension service and oral contraception services.
- All of this on top of ongoing increases in prescriptions volume (1.08 billion items were dispensed in 2022/23, a significant increase from the 850 million items dispensed 12 years previously).

2.7. In 2021, the Community Pharmacy Workforce Development Group published a review[8] which acknowledged that contributory factors to 'colleagues' leaving the profession are "*complex and multifaceted. They include concerns about pay, excessive workload and pressure, inflexible working hours, and a lack of opportunities for career progression".* The report's recommendations, however, did not make any suggestions as to how employers themselves might address any of these specific issues, which the PDA believe are underpinning poor morale and the choices that pharmacists make about where, when and how they practice.

2.8. Members of the Community Pharmacy Practice Group also raised concerns about colleagues leaving the sector to "*join other parts of pharmacy resulting in short falls in community pharmacy*".

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[5] Community Pharmacy Workforce Survey - data.gov.uk
[6] Pharmacies in England provide 65 million consultations a year - Community Pharmacy England (cpe.org.uk)
[7] Flu Vaccination - Statistics - Community Pharmacy England (cpe.org.uk)
[8] cpwdg-report-a-review-of-the-community-pharmacy-workforce-final.pdf (wordpress.com)

2.9. The NHS England Additional Roles Reimbursement Scheme[9] (ARRS) is often cited as the reason for so-called pharmacist shortages and recruitment and retention issues in community pharmacy, however data[10] from the General Pharmaceutical Council (GPhC) around the number of registrants shows that the total number of pharmacists on the register has increased sufficiently to accommodate the new (ARRS) roles whilst the number of community pharmacies has declined.

2.10. The PDA has spoken out about the pharmacist short falls rhetoric[11] and proposals from some employer representative organisations[12] to block the movements of pharmacists from undertaking roles in GP practice. The PDA believe that the right way to recruit and retain more employed pharmacists in the community pharmacy workforce is to address issues around the balance between the focus on patient care and safety vs. profit; levels of remuneration and workplace pressure; and the level of respect for the pharmacist from both patients and employers as a clinical health professional.

2.11. The PDA workforce temperature check results also highlighted that although many of the pharmacists that are now working in primary care did move from a community pharmacy role, 50% of those responding had moved more than 3 years ago. Respondents that had moved to primary care (from any sector) said the two most important reasons they had done so were for professional/career development and better working conditions.

2.12. Pharmacists recognise that a role in Primary Care is consistently seen as being part of the health service delivering care to patients and therefore matches their aspirations as a health professional, whereas too often aspects of community pharmacy are misunderstood by the public, and by others, as being just retail locations undertaking commercial transactions which is not what they qualified to undertake. Many primary care roles may offer more family friendly working patterns as unlike community pharmacy and hospital services they are not normally seven days per week.

2.13. However, in the defence cases that the PDA handles on behalf of members, many of those that moved to primary care are now finding that they are pressurised by GPs and others to work outside of their scope of competency or to meet unrealistic targets regarding dealing with volumes of prescriptions or consultation time with patients, which also leads to significant job dissatisfaction in this area of employment.

2.14. The PDA has produced a detailed strategy which is built upon the feedback consistently received from members and which provides numerous solutions as to how these problems can be resolved (See Section 7).

The ***'Wider than Medicines'*** strategy paper describes a re-engineering of the system of healthcare delivery in primary care. Its substantive but simple premise is that the current system is working hard but it needs to start working smart. It is in need of re-engineering to enable respective healthcare professionals to concentrate on roles which rely upon their

[9] NHS England » Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance

[10] gphc-register-data-december-2023.xlsx (live.com)

[11] The workforce impact of pharmacists working in Primary Care – what does the data tell us? | PDA Union (the-pda.org)

[12] Employers should accept responsibility for conditions in community pharmacy and fix the issues | The Pharmacists' Defence Association (the-pda.org)

unique skills. GP's concentrate on diagnosis, nurses on medical care, pharmacists on their expertise in medicines. A system which can work smart would release significant extra capacity for the benefit of the NHS, the taxpayer and so would improve the patients journey.

3. Introduction of the Pharmacy First Service in England

3.1. In general, PDA members welcome the development of services such as Pharmacy First, which has been operating in Scotland for several years, the Common Ailments Service in Wales, and the now introduced Pharmacy First service (PFS) in England, as they see the patient benefit and the opportunity to use their clinical skills and increase professional fulfilment. However, many PDA members in England have raised significant concerns about the timescales and methods of implementation of the PFS service, which commenced on 31st January 2024.

3.2. To assess the extent of the issues among its membership, research was conducted by the PDA (5th to 14th January 2024) in relation to PFS, the online survey saw over 3.500 responses[13].

3.3. One of the most significant areas of concern and directly linked to the workforce issues highlighted previously, was that 98% of respondents reported that they have insufficient staffing to operate existing community pharmacy services (prior to the launch of PFS), only 1% of pharmacists said that they have sufficient support staff all the time.

3.4. Concerns have been expressed about being unable to practice with competence and confidence. It has been impossible for some pharmacists to complete training for any gaps in clinical knowledge highlighted as part of a competency self-assessment due to course availability or an absence of protected learning time. The software needed to support the PFS, was only made available by the NHS on the morning of the big public launch. Many pharmacists are very concerned about the heightened risk of violence and abuse from the public because of anticipated demand for the service or unrealistic expectations.

3.5. Locum pharmacists, upon whom community pharmacy operators heavily rely on have also raised concerns around their training, remuneration and the behaviours of some employers ahead of the service launch.

3.6. The PDA has raised these concerns with NHS England and the Department of Health and Social Care on behalf of its members, however they did not agree to proposals put forward - a phased approach for the seven new clinical services, or to soft-launch / delay the go-live date to allow for more preparation for pharmacists who are delivering the service at the NHS frontline.

3.7. Further monitoring and research is being undertaken by the PDA to assess and support pharmacists' concerns as the service is launched.

4. Supervision proposals currently under consultation

[13] Frontline pharmacists' concerns about Pharmacy First implementation shared with DHSC and NHS England officials | The Pharmacists' Defence Association (the-pda.org)

4.1.The PDA believe that the proposals around Supervision legislation currently under consultation[14] by the Department of Health and Social Care (DHSC) need to be very carefully considered to ensure that the workforce and skill mix are appropriately enabled.

4.2.Having participated in the Pharmacy Practice Supervision Group, a cross sector group of stakeholders with interests in community pharmacy, a consensus position was found on how the law and regulations on supervision in community pharmacy should be changed to enable modern pharmacy practice. The PDA firmly believe that the group's recommendations[15] must be implemented through legislation, regulation and professional guidance to provide the appropriate framework for patient care, governance and skill mix.

4.3.An essential area of focus for the group was the importance of the physical presence of a pharmacist in the community pharmacy. The PDA want to see pharmacists developing more comprehensive clinical relationships with patients through the delivery of pharmaceutical care, to focus on medicines safety and to better support patients by becoming their medicines related champion from within the community pharmacy. This will provide enormous benefits for the NHS.

4.4.The PDA believe that the requirement for the presence of the pharmacist in the community pharmacy should be specified in primary legislation to ensure that patients can be assured of access to a community pharmacist, and that the NHS has confidence in the opportunity of pharmacists providing a broader range of clinical services, affirming their role as part of the primary care team.

4.5.The Pharmacy Practice Supervision Group's report clearly recommended that the physical presence of a pharmacist in a community pharmacy is essential in providing safe and effective patient care. The group also agreed that the existing permitted 2-hour absence rule should not change. The PDA reinforce that there must not be any changes to this, including for it to be made discretionary or to be extended, because patient safety and the ability to develop pharmaceutical care is optimised by the physical presence of a pharmacist.

4.6.The consultation also puts forward a proposal around the supervision of hospital aseptic services being supervised by a Pharmacy technician.

4.7.The PDA is currently consulting with its members on the proposals, and at the point of submitting this supplementary evidence, is yet to publish its final response to the consultation which closes on 29th February 2024. However, members of the Health and Social Care Committee are encouraged to consider the Department's proposals and the PDA would welcome the opportunity to provide a briefing about their views on the proposals and their potential implications.

5. Skill Mix

5.1.The PDA strongly advocates for a skill mix model which leans into the clinical training and expertise of a pharmacist, and the technical training and expertise of a pharmacy technician and seeks a collaborative approach which enhances fulfilment for both groups. We believe

[14] Pharmacy supervision - GOV.UK (www.gov.uk)
[15] Supervision-in-community-pharmacy-FINAL-APPROVED.pdf (the-pda.org)

that workforce capacity, good governance and the safe delivery of clinical services are all dependent on effective and appropriate levels of skill mix.

5.2. The PDA believes that the recent proposals put forward by the DHSC around enabling registered pharmacy technicians to use Patient Group Directions (PGDs) across England, Wales and Scotland in any setting[16] blur the distinction between the two roles and, when terms such as 'pharmacy professionals' are increasingly used, it gives the impression that they are one homogenous group.

This can bring concerns around competency and expanding technical roles beyond capabilities, potentially leading to role substitution (not skill mix), resulting in professional tension rather than collaboration. The PDA believe that there are significant parallels to be drawn on this issue and the current debate around Physicians Associates and concerns from the medical profession.

5.3. The central theme of the PDA response[17] to the consultation on whether pharmacy technicians should be allowed to deliver PGDs was around patient safety and the appropriateness and readiness of the current Pharmacy technician workforce to safely supply or administer medicines under the existing criteria for using a PGD.

5.4. The consultation document explained how PGDs operate and lists the healthcare professionals that are currently authorised in legislation to supply or administer medicines under a PGD. The consultation document, however, did not acknowledge that those healthcare professions have a minimum underpinning education at level 5 (with the majority having a level 6 or 7 qualification). The pharmacy technician register was created only in 2011, prior to that they were not regulated and; they only have a basic level 3 qualification.

5.5. Around 50% of the current pharmacy technician workforce (this figure is from a freedom of information release from the GPhC) entered the register via a 'grandparent' clause. The 'grandparenting' approach to the initial registration of pharmacy technicians meant that a pharmacist could sign an individual as being competent to be registered.

5.6. However, the pharmacy regulator (the GPhC) does not hold any record from the previous regulator (The Royal Pharmaceutical Society of Great Britain) of any assessment having been conducted as to the suitability of the qualifications relied upon during grandparenting to allow someone to work as a pharmacy technician.

5.7. The former Chair of the GPhC told an RPS conference in September 2014 that because of grandparenting, there were some very variable standards amongst pharmacy technicians. He explained that it was therefore not possible for the regulator to take a blanket view and to recommend to pharmacists what roles they should delegate to pharmacy technicians. A generic approach to the entire group was not possible. The level of public protection provided by the grandparenting clause in the present day is questionable and it would be difficult to rely upon the assurance it provides if the roles of pharmacy technicians were to evolve.

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[16] Proposal for the use of patient group directions by pharmacy technicians - GOV.UK (www.gov.uk)

[17] Microsoft Word - PDA response to DHSC on proposals for pharmacy technicians_PGD consultation - FINAL (the-pda.org)

5.8. It is the view of the PDA, that most of the pharmacy technicians who have joined the register by the more recent GPhC examination route are working in the hospital pharmacy sector, as this is the sector that has a structured career framework for pharmacy technicians. Whereas the vast majority of those in the community pharmacy setting, (where no such structured career approach exists) have been predominantly 'grandparented'.

5.9. The central underpinning requirement for the use of a PGD by a healthcare professional is that this one individual healthcare professional undertakes the whole process from start to finish. No part of the process can be delegated to another person. This includes making the clinical decision on whether the product is safe and suitable for that individual patient following a full and comprehensive history taking, including an analysis of underlying medical conditions, contra-indications and dose adjustments.

5.10. Whilst PGDs can stipulate additional training requirements before a healthcare professional undertakes using the PGD, this is not a substitute for the underpinning level of knowledge required to make a clinical assessment on whether to supply or administer the medicine identified in the PGD. With Pharmacy Technicians trained to NVQ level 3, the underpinning knowledge required to be able to safely handle PGDs singlehandedly is just too low.

5.11. Pharmacy technicians are valuable members of the pharmacy team and whilst the PDA did not support the proposals around PGDs for the reasons outlined in its response to the consultation, it is keen to work with stakeholders to find a solution which meets the needs of patients and the NHS and provides professional fulfilment for both pharmacists and pharmacy technicians.

5.12. The PDA's proposals rely on skill mix and not simply role substitution (the current DHSC proposal) and would enable both pharmacists and pharmacy technicians to work collaboratively, utilise their own unique skills and training, and above all deliver safe practice and good governance.

5.13. The PDA encourages members of the Committee to give serious consideration to the issue of patient safety and appropriate skill mix in relation to the expansion of the role of pharmacy technicians as part of their current inquiry into pharmacy.

5.14. These issues are particularly apposite, since the newly launched Pharmacy First service in community pharmacy in England is entirely a PGD driven model. If the current DHSC proposals on pharmacy technicians being allowed to deliver PGDs goes ahead, the PDA believes that this leaves patients structurally exposed to safety and quality concerns.

6. Working smarter – pharmacists' role in commissioning

6.1. Members of the Committee were interested to hear views on pharmacists' role in commissioning. The PDA believe that **pharmaceutical care** is the right approach for the NHS to take, based on the significant public investment in medicines, the rise in polypharmacy, the number of hospital beds occupied by patients who have been impacted by adverse drug reactions and the need to better support people with long term health conditions closer to where they live and work.

6.2. Pharmaceutical care is defined as:

"A patient centred practice in which the practitioner assumes responsibility for a patients medicines-related needs and is held accountable for this commitment." *Hepler and Strand*

6.3. The PDA currently sees some barriers to the effective provision of pharmaceutical care, due to the fragmented nature of the NHS structure, and during the evidence session suggested some improvements as to how pharmacists could be more effectively deployed across primary care, particularly with the opportunity of more pharmacist independent prescribers.

6.4. The PDA's policy, **Wider Than Medicines**[18] looks at integrating the work of GP surgeries, community pharmacies and hospitals through the more integrated roles of GPs, primary care pharmacists, GP practice-based pharmacists, group practice pharmacists, hospital pharmacists and community pharmacists. By taking charge of the medicines and pharmaceutical care agenda, it suggests a model which could help to secure the long-term health of the public, as well as meet important NHS objectives.

6.5. Wider Than Medicines reads:

"*The patient journey is at its best when the various members of the healthcare team are able to focus upon their unique professional skills. In the case of GPs, this is diagnosing patients; for hospital staff this is providing specialist treatment, and for pharmacists, this is the safe and effective use of medicines and specifically in the provision of pharmaceutical care. This can only occur if it is done within a managed and coordinated framework.*

By focusing on interventions throughout the patient care journey, we can eliminate some of the silo working in the system. Through the creation of a community of practice we can ensure that pharmacists, doctors and others across all sectors can apply their unique skills collaboratively, so that they can achieve joint objectives in a much more efficient and joined up way. This proposal seeks to explore what contribution pharmacists as experts in medicines in particular can best make in this new joined up community of practice".

6.6. With a Chief Pharmacist appointed at Integrated Care Board level, a more strategic and systematic approach could be taken to optimising the contribution that pharmacists could make to patients if a pharmaceutical care approach was taken. Currently there are multiple competing priorities, models and commissioning approaches which could be better coordinated by the leading primary care organisation and therefore, be more effective. Wider Than Medicines suggests how this model might be structured.

[18] 634_A4-PDA-12pg_Wider-Than-Medicine_V8_LRES.pdf (the-pda.org)