Written evidence submitted by Community Pharmacy Lincolnshire (APE0022)

About Community Pharmacy Lincolnshire

Community Pharmacy Lincolnshire is the Local Pharmaceutical Committee and is the representative statutory body for all Community Pharmacy contractors in the Lincolnshire area, whether independent or multiple. The committee works with the Integrated Care System and other key healthcare stakeholders including local councils and other organisations as necessary to ensure that the provision of pharmaceutical services continues to be an integral part of Health and Social Care in the county and that community pharmacy is truly represented. www.pharmacylinconshire.org

Responses on the Government commitments under evaluation

We are responding to the consultation as the representative body for community pharmacies in Lincolnshire. The Pharmaceutical Services Negotiating Committee (PSNC) has responded to a number of these areas on behalf of Community Pharmacy in England. PSNC, soon to be re-named Community Pharmacy England, promotes and supports the interests of all NHS community pharmacies in England. We have noted below our support for PSNC's response in relevant areas and have also added additional information where necessary.

Policy Area 1: Community Pharmacy

Community Pharmacy Commitment 1 "Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Commitment Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS."

We support in principle the response of PSNC in this area.

An adequately funded PhAS is essential in a rural county such as Lincolnshire, where a high proportion of dispensing GPs (around one third of practices) reduces the income from dispensing for pharmacies so maintaining a pharmacy in a rural area is not financially viable without additional support. In many areas of Lincolnshire public transport is very limited or non-existent and some patients do not have access to private transport, meaning that being able to access health advice and guidance from a local pharmacy is vital.

Community Pharmacy Commitment 2 "Review the funding model and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery"

We support the response of PSNC in this area.

Whilst the move to a service-based model for community is the appropriate direction of travel, the lack of funding to facilitate this has caused harm to the sector. Currently service income and dispensing income come from the same pot that has **remained static in value since 2015.** Many services rely on inward referral so pharmacies that do not receive referrals and therefore cannot offer these services, for no fault of their own, are receiving less for their core dispensing work while costs are spiralling and they have no way of

increasing their income. Even when pharmacies that are able to do offer services, they are perversely reducing the amount of dispensing income they receive. In lay man's terms, this is a bit like offering to pay a staff member overtime for doing extra hours, but the more overtime they do the less basic salary they get paid. This seems counterproductive and not a good business model, hence many contractors are now reassessing their pharmacy sites and/or access times.

The failure to provide appropriate resources to community pharmacy has reduced patient access to vital, front line community pharmacies as many pharmacies have closed, including Lloyds pulling out of all of their Sainsburys pharmacy branches and many other pharmacies reducing their supplementary hours to reduce their costs. This has reduced out of hours access for patients and thereby increased pressure on costly accident and emergency services, as patients have nowhere else to go – this is counterproductive and will be more costly overall than increasing the pharmacy budget. The closure of local pharmacies has negatively impacted patients and continues to do so. The scope of the commitment should have included appropriate funding increases rather than reducing the base income level of pharmacies to an unsustainable amount.

Policy Area 2: Integrated Care (including patient safety)

Commitment 1 "Deliver a new Community Pharmacist Consultation Service with referrals from NHS111, GPS and A&E."

We support the response of PSNC in this area.

We would note that the funding of systems (such as PharmRefer and EMIS Web) that link the GP with the pharmacy to allow direct referral into pharmacy software are essential in enabling efficient roll out of these services and appropriate patient experience. A referral pathway using nhs.net email will not be suitable for the increased capacity we are seeing in service referrals.

Commitment 2 "Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicine Service')."

We support the response of PSNC in this area.

Policy Area 3: Hospital pharmacy

Commitment 1 "To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024."

PSNC gave no response to this section.

The use of electronic prescribing is vital across the system if integration between secondary and primary care is to be efficiently managed. A fully functioning, integrated EPMA system is necessary to enable maximum benefit from the Discharge Medicines Service (DMS) for example. In Lincolnshire, unfortunately, unforeseen delays mean the United Lincolnshire Hospitals Trust (ULHT) have not yet got a fully functioning EPMA system in place across the hospital network.

Additional support to ULHT may have been helpful in facilitating the earlier roll out of this essential change for the Discharge Medicines Service in Lincolnshire. Once the EPMA is in place in Lincolnshire this will have patient benefits. However, currently with no EPMA in place at ULHT Lincolnshire patients are disadvantaged as DMS cannot be widely rolled out across the county. It is disappointing that Lincolnshire pharmacies have

been unable to access their share of the global sum in relation to DMS due to delays at ULHT, putting further pressure on the financial resources in pharmacies and impacting their sustainability, ultimately risking patient access to services.

Policy Area 4: Workforce, Education and Training

Commitment 1 "A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists."

We agree in principle with PSNC's response in this area.

Whilst this aim is laudable, there needs to be ongoing assurances of continued and relevant support for the community pharmacy workforce (and this should include pharmacy technicians and pharmacy teams, as well as pharmacy staff). System level work is needed to also ensure that the community pharmacy workforce have access to some funded Protected Learning Time to allow for further skills development.

Independent Prescribing

The current commitment to allow funded places for the current community pharmacist workforce to train as IPs is welcomed. However, the funding for course fees only addresses one of the barriers, with the others being time to complete the learning (which can be significant) and perhaps more pertinently the identification and co-operation of Designated Prescribing Practitioners. For many this latter issue can mean the difference between being able to complete an IP course or not and many community pharmacy organisations indicate that this is the 'rate limiting step' in training the current pharmacist workforce. With increasing work pressures and changes to their contract, GPs are increasingly less able to offer their time to support this vital training unless they are funded to do so. Therefore it would be beneficial (if not essential) to consider how DPPs could be funded for their role in supporting trainee IPs.

Additional funding to support learning time would also be welcomed; many pharmacists manage this intense period of learning using their limited day's off and annual leave.

Clinical Skills Learning

This is again welcomed, but care needs to be taken that this is relevant and meets the needs of the current and future community pharmacy workforce. Working through accessible and established organisations such as CPPE, as well as utilising new providers allows the workforce to choose the right learning provider for them. Integration of learning records then becomes a potential concern for some. We should also be mindful of the changes to the initial education and training standards, but also recognise the value of experience and skillset of the current workforce, and therefore not expect pharmacists to have to 'tick boxes' to meet service requirements but should be recognised and treated as clinicians with expertise.

Initial Education and Training of Pharmacists

The changes to the initial education and training of pharmacists, whilst set to improve the integration of pharmacists within clinical systems, is fraught with practical difficulties. Undergraduate pharmacists do not currently receive any bursaries to support them with their learning, and so are committing to a four year (and arguably vocational for roles within and supporting the NHS) degree programme at their own cost. This can lead to some considering alternative careers.

Lack of Funding for Pharmacy Students: ***The detail***

It is important to highlight under workforce education and training the inequalities that exist in pharmacist training bursaries in comparison with other NHS clinical roles. When we want to encourage more students to train as pharmacists, surely a level playing field is necessary to make pharmacy equally as attractive as other health professions for the brightest and best students. If we do not have people coming forward to train as pharmacists, provision of additional training availability will be irrelevant.

To provide clarity, if students are starting a course from 1 September 2020 onwards, they can apply for NHS Learning Support Funding if they are on one of the following pre-registration undergraduate or postgraduate courses:

- dental therapy or dental hygiene (level 5 and 6 courses)
- dietetics
- midwifery
- nursing (adult, child, mental health, learning disability, joint nursing, and social work)
- occupational therapy
- operating department practitioner (level 5 and 6 courses)
- orthoptics
- orthotics and prosthetics
- paramedics (DipHE and FD courses are not eligible for NHS LSF)
- physiotherapy
- podiatry or chiropody
- radiography (diagnostic and therapeutic)
- speech and language therapy

Nursing, midwifery and allied health professional students as listed above who are:

- attending a higher education institution in England in the 2022/23 academic year
- in active study, whether academic or practice learning
- eligible for student maintenance and tuition fee loan support from the Student Loans Company

Receive:

- a training grant of £5,000 per academic year
- parental support of £2,000, if you have at least one dependent child under 15 years, or under 17 years if registered with special educational needs
- money back for excess travel and temporary accommodation costs (Travel and Dual Accommodation Expenses) while you're on your practice placement

Pharmacy students do not qualify for any support from the NHS Learning Support Fund and receive no NHS training bursary.

If Ministers truly value the role of pharmacists within our integrated care systems, with current policy urging patients to see their pharmacists for minor ailments to support the system, then surely students should be adequately supported financially. Making pharmacy the least well financially supported option in health care professions will not solve the current workforce crisis and assist the DHSC in their aim to increase the number of pharmacists trained in the country. Consideration should be given to adding pharmacy students to the LSF funding list.

The Foundation Training Year

From an employer perspective, the changes to current undergraduate courses also place significant burdens to support placements; these are somewhat funded but not at medical tariff rates and so can prove costly

for providers and challenging for HEIs to organise and manage. From what we know at this stage, the planned changes to the Foundation Training Year also present significant concerns in the future too; multi-sector placements and IP training all require careful co-ordination, implementation and management, all with NHS funding that does not cover the required trainee's salary, ignoring the significant administrative and training burden that such placements add. This may cause some organisations to withdraw from supporting training (we have already seen several community pharmacy organisations cease to offer foundation training places within the current approach, and the future methods place an even greater cost and time burden on employers). This therefore needs some careful rethinking.

Another area we feel needs highlighting is the proposal to move all recruitment of trainee pharmacists via Oriel. Contractors have raised concerns about this as they prefer to recruit directly for a variety of reasons. A pause is needed on the roll out of Oriel and a review undertaken, as there are issues around the system that could cause contractors problems - for example, one Lincolnshire contractor noted recently that they have an individual that has been offered a placement in one of their pharmacies via Oriel, and the contractor did not know they needed reasonable adjustments to be in place. The employer needs to make that assessment, as it is the employer who will deem an adjustment needed as reasonable or otherwise. The system is too rigid.

Commitment 2 "Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists."

We agree in principle with PSNCs response in this area.

Skill Mix

This is welcomed with cautious optimism, but also requires recognition of the change that may be required for pharmacy technicians in particular; to date, their role in community pharmacy settings has been somewhat stilted and therefore many have sought work in secondary care or other primary care settings where they may feel more able to use the skills and knowledge gained through their initial training.

We'd also seek, alongside this move to increase skill mix, a move to support community pharmacy providers to train more staff as Pharmacy Technicians. Currently, this is almost entirely funded by community pharmacy contactors and carries a significant cost.

May 2023