# **Community Pharmacy Expert Advisory Group Agenda**

**Monday 29th January 2024 - 7.30pm – 9.30 pm**

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## **1: Welcome, Apologies and welcome Led by Janice 5 mins**

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| **Purpose** | To welcome and note apologies. |
| **Outcomes** | Apologies noted were: -Aron Berry and Mohamad Abrahim.Vivyana Matanda – The group noted she had been on maternity leave and would not be returning to the CPEAG.In attendance: -Janice Perkins – Chair, Paul Jenks, Waqas Ahmad, Patricia Ojo, Sarah Passmore, Gary Evans, Jonathan James, Sobia Janjua, Diane Robertson and Nick Thayer. |

## **2: Pharmacy Supervision – led by Alwyn 60 mins**

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| **Purpose** | The DHSC is seeking views on proposals to modernise legislation governing the supervision of activities by a pharmacist in a pharmacy.The consultation can be found [here](https://www.gov.uk/government/consultations/pharmacy-supervision).Through engagement with members and Expert Advisory Groups, feedback will be provided to the three country Boards at the February Board meetings to help shape the response of the RPS.We will concentrate on Proposal 1 and 2 in the consultation, which are most pertinent to community pharmacy, questions to consider include.* Do you agree or disagree with the proposals?
* Are these proposed changes enabling enough, or do you feel they go ‘too far’?
* If these changes are to be made, what ‘checks and balances’ would need to be in place?
* What assurances on competency and training are required for pharmacy technicians and other team members?
* Are there any other legislative barriers to delivering a fuller range of pharmaceutical and health promoting services?​
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| **Outcomes** | AF provided the background to the stakeholder events that had been happening and the process of shaping the RPS response to the consultation. CPEAG views will feed into National Board days and taken into consideration when preparing RPS response. In discussion the following issues were noted: -**Proposal 1: Introducing authorisation of a pharmacy technician by a pharmacist*** A rich discussion with a variety of views and acknowledgement that the detail to follow in the regulation and standards/guidance will be key.
* Much of the group were in general favour of the amendment, however concerns from some members were expressed and felt more clarity was needed at this stage (not to wait for the regulations) to fully understand the implications of a change.

A summary of the discussion is as follows:* The change in the legislation is intended to be enabling and is, in effect, already happening in practice. Pharmacists increasingly spend more time in the consultation room away from the dispensing process to deliver clinical patient facing care through vaccinations, common ailments scheme, prescribing services and cannot practically supervise everything going on in the pharmacy.
* This is seen as needed to enable continued development of community pharmacy practice, ultimately, it’s not compulsory but a tool available to pharmacists. However it may be difficult for an RP to not authorise and delegate in a particular pharmacy if that is normal practice on all other days.
* This will add parity with distance selling pharmacies who have no control of the medicines after they leave the pharmacy.
* Enables parity with other healthcare settings such as GP practice, where lots happens under delegated authority.
* The amendment potentially protects the responsible pharmacist, as subconsciously this is happening in pharmacies, this provides legislation to support.
* Removes some of the grey areas around supervision in terms of being on the premises i.e. where the toilet is a number of floors up within the premises.
* The ‘who, how and what’ detail will come in the GPhC regulations.
* Changes to RP and SP regulations are critical to this – will follow and be consulted on, GPhC regulations need to be stringent when initially set out and could then evolve over time.
* Pharmacy technicians who are authorised must be confident and competent to carry out the supervision, this competency needs to be assured. There was a query around whether all pharmacy technicians wanted this added responsibility. It was felt there would be a mixed appetite for this from pharmacy technicians working in practice day to day. It is imperative pharmacy technicians engage with any amendments to ensure understanding of their individual accountability.
* Supports the better use of skill mix and the development of pharmacy team members and potentially job satisfaction and recruitment into the profession.

**Barriers/challenges*** Supervision will remain a ‘minefield’ and there needs to be greater clarity around who is ultimately accountable, or the proportionality of accountability.
* We are going to see a greater need for pharmacy technician training within community pharmacy. Some pharmacies have paused training pharmacy technicians, and many have been lost to roles in primary care.
* There was concern around whether pharmacy technicians would have the choice themselves or whether will could feel pressured into accepting responsibility.

*There are potential unintended consequences and these are outlined as follows** Potential for patient confusion/different type of service on different days within the same pharmacy or between pharmacies e.g. an RP is happy to delegate authority, and a patient can pick their prescriptions up whilst the pharmacist is at lunch, but a different pharmacist at a later date does not and the patient can't collect. This could lead to an increase in complaints and potentially pressure on pharmacists.
* There could be difference between patients depending on the medication they are on which could mean some could collect and others couldn’t. Patient engagement and understanding will be crucial.
* Locum pharmacists new to a pharmacy are naturally going to be cautious around delegating authority. If delegation is the norm in that pharmacy, it can be confusing for both staff and patients.
* If pharmacy technicians are unable to supervise P medicine sales, when the pharmacist goes to lunch, a patient may be able to collect their prescription but unable to buy P meds, which may increase patient frustration.
* There may be variation between pharmacies within a locality, which will add to patient confusion.
* Pharmacies that don’t have a pharmacy technician may potentially be disadvantaged over ones that do, in addition, if a pharmacy technician has a regular day off, services will run different in that pharmacy that day to others, potentially confusing for patients.
* It was noted that this will be commercial decision about whether to train and recruit additional PTs and should not hinder progress.
* Practically speaking, under current funding arrangements pharmacies will struggle once this is implemented. Pharmacy technicians will naturally want higher salaries for the increased responsibility, but the funding envelope will constrain contractors on any uplifts. This may unintentionally exacerbate workforce problems.

**Concerns raised.*** There is currently not enough understanding and definition around the proposals, missing the detail needed at this stage.
* Maintains the ‘parenteral’ role of pharmacist and pharmacy technician, not remove it.
* The responsibility of the delegated task needs to be with the registered professional undertaking the task. So, an ACT should have legal responsibility for the accuracy check instead of the RP, and if we are going to delegate to a registered professional that should be the rule.
* Unintended consequence – pressure on pharmacists to ‘authorise’ and they may not be comfortable.
* What’s the impact of not having a PT and will this hinder service provision in those pharmacies i.e. can you still be in the consultation room and supervise. Guidance will be needed.
* Worryingly though quite rightly the DHSC indicate a potential risk to patient safety in their impact assessment around this. What we need to consider is whether the benefits outweigh the risks.
* There’s ongoing work to allow technicians to undertake services. We wouldn’t want these changes to hinder this or prevent PTs from supporting teams in this way.

**Proposal 2: handing out of pre-checked bagged medicines to patients in the absence of a pharmacist.*** There was unanimous agreement that this was a sensible way forward.
* We currently have situations where patients are able to collect prescriptions from a locker box if the pharmacist is offsite at lunchtime, but if they come into the pharmacy, they are unable to collect it.
* Pharmacist providing clinical check will know if it needs a pharmacist intervention – can identify which prescriptions can’t be given out and utilise ‘flags’ e.g. ’see pharmacist’ stickers.

**Other legislative barriers*** NHS service specs need standardisation and consistency. Some refer to services being available all the time, and sometimes this is not achievable.
* NHS terms of service need to be updated, for example, to allow protected time for learning.
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## **3: Emergency Hormonal Contraception – reclassification of levonorgestrel from P to GSL – led by Alwyn 30 mins**

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| **Purpose**  | We are anticipating the Faculty for Sexual and Reproductive Health to shortly advocate for a reclassification of levonorgestrel from P to GSL.British Pregnancy Advisory Service already advocates for reclassification.<https://www.bpas.org/media/xhgd03wj/levonorgestrel-gsl.pdf>We are looking to achieve an RPS position that can be taken should any future proposal arise regarding a switch of levonorgestrel from a P to GSL medicine. Theses discussion will feed into the February National Board meeting. |
| **Outcomes** | CPEAG members expressed a strong view that it supports the timely access to EHC for all women through commissioned services via community pharmacies. Concerns were expressed that the safety of patients would be compromised if purchasing a GSL medicine as there is unlikely to be a check for appropriateness, counselling, and advice at the point of supply.Patients have access to a pharmacist for advice and counselling in a consultation at a pharmacy and this must remain to ensure appropriate support is provided for access to other relevant sexual health services. * Healthcare advice from a pharmacist completely missed if sold as GSL – lots of opportunistic interventions highlighted around contraceptive advice, the lack of understanding in some patients of contraception entirely, being able to educate and signpost these patients as necessary for longer term options.
* Safeguarding could be completely missed with reclassification and sale through an unregulated non-clinical environment with no healthcare professional input.
* What is clinically necessary? BMI over 26 or >70kg, two tablets are needed, patients will not know to purchase two (and may not be able to afford to)
* Levonorgestrel will not work after ovulation, shared decision making. Coil would be the most effective at that point. Ulipristal is a better clinical option for many patients now, but patients would miss all of this advice and access to the best clinical option with reclassification.
* MECC – not just selling a product, goes against public health message of using pharmacy and pharmacists for health interventions.
* Patients are potentially going to feel ‘more judged’ if they are buying at a petrol station rather than through a clinical setting.
* Risk to decommissioning of free locally commissioned EHC service which means some patients won’t have access due to cost. We would like this adding to the new national contraception service to remove the postcode lottery of local commissioning and give free access to all supported with professional advice.
* Pharmacists who are able to provide this service free of charge for patients, have not sold the medicine for many years, patients see the value in a commissioned service.
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## **4: AOB**

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| **Purpose**  | To discuss any other business |
| **Outcomes** | Alwyn thanked the group for their input into the recently published statement in partnership with RCN, prescribing and dispensing by the [same healthcare professional](https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/prescribing-and-dispensing). |