Scottish Covid-19 Inquiry

Witness Statement

Organisational Statement of **Maurice Hickey** on behalf of the **Pharmacists' Defence Association (PDA)**

Introduction

1. My name is Maurice Hickey. My date of birth is Personal Data I am employed by the Pharmacists' Defence Association (PDA) as Scotland's Head of Policy. I also continue to work as a pharmacist in a locum capacity approximately once a week. The PDA's position is that it is important for staff to remain up to date and in touch with practice on the ground.

2. My details are known to the Inquiry. I am happy to provide a statement to the witness statement takers today and have signed the consent form.

3. I am happy for my information to be contained within any reports and for my statement to be published. I am willing to provide oral evidence if required by the Inquiry to give evidence at the public hearing.

The Pharmacists' Defence Association (PDA)

4. PDA is the largest representative body and the only independent trade union exclusively for pharmacists across the UK. There are around 66,000 registered pharmacists in the UK, and the PDA is the collective voice of employed and locum pharmacists working on the NHS frontline and across all healthcare settings, including GP practice, community, hospitals, health boards and prisons.

5. The PDA and has more than 38,000 members. In Scotland we have about 3,600 members, so UK membership is 10% Scotland specific. Within each of these groups we have locums. We have a number of members who have portfolio work whereby they perhaps work 2 days per week in community pharmacy and 3 days in a GP practice, or some other ratio, we also have members working in GP practices and the hospital sector. We are the largest representative body for pharmacists by a long way.

6. The PDA defends members when they are faced with conflict and challenges employers, regulators and government on their behalf. Membership automatically includes Professional Indemnity and Legal

Defence Costs insurance to safeguard and defend our members' reputations.

7. We look after student pharmacists as well. The degree and the registration year now includes much experiential learning, and they go out to work in pharmacies. The union indemnifies them free of charge and many remain as members once they graduate.

Professional Background

8. I have worked as a pharmacist for almost 42 years. Over that period, I have worked in community pharmacy as an employee and spent years as a contractor pharmacist. I have a history of advocacy in pharmacy and have served on a number of boards.

9. I was a member of the Royal Pharmaceutical Society of Great Britain Board 20 years ago. I was on their Scottish Executive Board. I sat on the Community Pharmacy Scotland Board, from 2005-2012. Basically, any Scottish Boards you can get elected to, I have sat on.

10. In 2012, I moved to Australia and worked there for five years. When I came back to Scotland, I began to take short term contracts. I have locumed since then. I was a locum during COVID-19.

11. When the job came up at PDA it was part of restructure to improve the coverage in Scotland. I applied for the National Officer position but was preferred for this job as policy head. I started the job in September 2021.

12. The work within the position is varied. I work on all policy across Scotland. I also do a lot of public affairs. It is quite a broad spectrum. It is the policy of the Union that all pharmacists should also work in practice each week to keep abreast of developments which I do.

13. During the pandemic (prior to starting at PDA) my work varied, and I would locum periodically some weeks. It was not so critical for me as I was an established pharmacist, but for my younger colleagues it was more important as they needed the salary every week. You get no sick pay or employment benefits as a locum. Whilst I could find the shifts I wanted, many locums could not find work or even had it cancelled. I am willing to travel so it was perhaps easier for me to find work. I worked in Edinburgh, East Lothian, and the Borders.

General Impacts

14. The first major impact for pharmacists was the surge in workload – it completely changed overnight. GP surgeries had closed and access to other parts of the healthcare service was stopped. This contributed

significantly to this surge. Pharmacies were the only part of the NHS that stayed open throughout the pandemic.

15. As with most people, pharmacists had to change the way they worked day to day. Queuing systems were implemented, and a lot of community pharmacies moved to a 'one in one out' policy which caused some discontent with patients. The fact remained that we were the only place on high streets that were open.

16. However, this surge did not happen everywhere. Some people in city centre pharmacies suddenly had virtually no work whatsoever because there were no people about. For example, for a pharmacy in a city centre or near a busy railway station found that pretty much all of their patients disappeared overnight. It took some time for staff in that situation to be redeployed to other branches.

17. Quite quickly after lockdown, the health boards instructed all pharmacies to close to customers between 09:00-10:00, 13:00-14:00 and 16:00-17:00. This was to allow staff dedicated time to clean the premises, so staff were still working. Even though opening hours were reduced, the increase in workload was such that many of us were still struggling to cope. It was common for staff to work extra hours beyond the stated working hours.

18. There was also extra demand from patients, many of whom were fearful and pharmacy staff were the only health workers they had access to. There was also significant stockpiling of everyday and prescription medicines.

19. A number of GP surgeries were doubling prescriptions to ensure customers/patients would not run out. For example, instead of 4 weeks' worth of prescription, they were issuing prescriptions for 8 or 12 weeks at a time. This also contributed to subsequent shortages of medications, particularly for devices like asthma inhalers.

20. Due to the nature of the COVID-19 virus, inhalers and other medications or aids for breathing difficulties disappeared overnight leading to panicked patients, some of whom suffered from conditions like chronic obstructive pulmonary disease (COPD). Supply did eventually pick up and went back to normal, but it became hard to anticipate supply shortages and demand. It was relentless.

21. As pharmacists, we often saw people who said their GP had referred them to us, but it generally was not the doctor but the receptionist who had told them to visit the pharmacy. Every morning started with a queue of patients saying they'd phoned the doctor, asking us to have a look at the problem, look into their throat for which they had to take their masks off. It discomforted a lot of staff that this was happening.

Many surgeries were really good and were still doing consultations and seeing patients, but others I can only describe as unhelpful and were just sending patients to us to be triaged.

Pharmacist and Pharmacy Student Health and Wellbeing

22. Pharmacists worked as frontline health workers throughout the pandemic in every setting including on COVID-19 wards. Meanwhile, for many patients a community pharmacy was their first and often only direct point of contact with the NHS throughout the pandemic. These increased staff workloads to unforeseen levels.

23. While most other parts of the NHS locked down and minimised direct contact with patients, community pharmacies were rarely closed and pharmacists had significant contact with patients, securing the supply of medicines, and providing access to advice and treatments.

24. Social distancing was entirely impractical in many settings and was effectively impossible in the cramped confines of many community pharmacies, therefore close proximity of other staff and patients was a major cause of concern for most pharmacy teams. These concerns were poorly acknowledged by many managers and pharmacy owners. Also, pharmacies in general were given lower priority for the provision of personal protective equipment (PPE).

25. Many staff became ill due to COVID-19 and other illnesses and as a limited resource, the remaining staff found themselves working longer and more hours than normal. This was a contributory factor to the scale of burnout recorded by several surveys amongst these key workers. Once we got to the point where people were regularly mask-wearing, many staff remarked that they did not seem to get sick as they generally did at certain times of the year, unless it was with COVID-19. It was remarked that they did not seem to catch the normal colds or flu, that we somehow missed out on the usual 'autumn illnesses'. Anecdotally this was put down to mask wearing.

26. The main issues with the health and welfare of pharmacists were all centred around workload and the stresses of dealing with people. As a Union, the levels of burnout we were recording was high. The PDA's annual Safer Pharmacy Survey noted a pronounced spike in problems amongst pharmacists, noting issues of mental health and burnout rates in excess of 90% in general. Pharmacy opening hours were not as long as usual, but staff were still working the same or a greater number of hours. We were trying to get through a huge volume of work in what is often a cramped workspace, made more claustrophobic by the protective measures that were being taken. We will submit to the Inquiry our Safer Pharmacies Charter and also our Safer Pharmacies Surveys from 2020, 2021 and 2022.

27. When people did get ill with COVID-19, this could on occasion lead to the whole pharmacy having to close suddenly. Some larger organisations could quickly source more staff or move staff around, but the smaller pharmacies could not do that.

28. Community pharmacists were required to undertake new tasks and quickly embrace novel ways of working; these included the launch of the expanded minor ailments scheme as "Pharmacy First" and the introduction of patient group directives (PGDs) to allow the supply by pharmacists of a series of prescription only drugs. The training requirements for this were not insignificant, but often pharmacists were given little or no support from the private business contractors who own pharmacies. Training was required to be undertaken in their own time in addition to the increased hours many of them were being expected to work to meet increased demand from patients. This had to be done in family time that should have been allowed to them for recovery and recuperation from the pressures of work, and they were often not paid or offered lieu time in respect of these additional activities.

29. It is important to note that many of the people running pharmacies are not pharmacists; a lot are commercial managers. For example, out of 1,300 community pharmacies in Scotland, around half are owned by large UK wide national chains. They are often managed by non-health clinicians who prioritise commercial imperatives rather than patient wellbeing as they have to hit company targets.

30. Although pharmacy owners in Scotland were paid specific funds to provide training to their staff to enable them to cope with the new reality, very few of the staff received any benefit in the form of protected or paid learning time. It was routinely expected by many employers that this was to be done in their 'own' time or at home. This was often to the detriment of the quality of their life outside of work at a time when it was anything but normal.

31. In addition, pharmacists had to manage increased patient expectations, act as disseminators of public health information, and deal with the frustration faced by many who were failing to access services elsewhere. They suffered significant harassment from some patients, carers, and the public in general.

32. There is a belief in some quarters that if you work in community pharmacy, you are not in some abstract way fully part of the National Health Service. We heard this in a lot of comments. The fact remains that pharmacists and their teams were delivering frontline NHS services, and it was an insult that we were not considered properly part of the NHS.

33. Surveys of pharmacists' health and wellbeing undertaken during the COVID-19 pandemic showed high levels of symptoms of burnout – up to 89% amongst pharmacists and their teams which is significantly higher than pre-pandemic. Around a third of pharmacists expressed a desire to leave the profession and a further third said they were looking to change jobs.

34. Many pharmacists reported a decline in the numbers employed in their wider teams as many trained support staff left. Trained technicians (who undertake responsible and important work) are paid a relative pittance and had to encounter sick people being aggressive towards them. They could earn more working at a local supermarket.

35. A problem for frontline staff was that they were not furloughed and if they became unwell, they then had to rely on statutory sick pay and they lost a huge part of their salary. I was personally aware of a few staff who felt unwell but had returned to work because they could not afford to be off. This made their recovery harder. It should be mentioned here that locum pharmacists, being self-employed, received no sick pay whatsoever.

36. A lot of people just left. I include myself in that as well, I looked to get out and did by joining the PDA. It became unpleasant to work in a pharmacy and it was so draining. I felt ill all the time. If there was another pandemic, I would not work. It was a profoundly unpleasant experience and I don't think I could cope with it a second time.

37. In hospitals they had slightly different problems, in that staff were often working away from patients, but pharmacists still had to make ward visits as required. The supply of PPE in this environment was better than in other areas of pharmacy but they encountered many of the same problems. During the first lockdown, pharmacists reported going into wards with a surgical facemask on but would often have to wear the same disposable mask all day.

38. The disconnection some community pharmacists felt with the NHS per se was reinforced by pharmacy contractors who did not adequately cascade the ever-changing guidance and information being circulated by the NHS to its staff.

39. A further factor affecting wellbeing was the exhausting and continual nature of the pandemic. Later on, there were problems with people becoming rundown and getting ill.

40. The difficulties were amplified by mixed messaging between the Scottish Government and Westminster. This was worsened by the big pharmacy chains communicating advice in England as the advice that

applied across the UK including in Scotland. Some pharmacies were receiving Scottish information and some English information.

41. In April 2022, the PDA was made aware of a pharmacy chain who had released guidance stating that if you had COVID-19, you could still go into work if you did not have symptoms. This had been allowed in England but was not the case in Scotland and was completely at odds with Scottish Government advice. We wrote to the chain concerned and they refused to withdraw their statement. Eventually, Humza Yousaf MSP, the then Health Minister, contacted them, and he got them to confirm the geographic extent of the guidance.

42. The general public has a positive view of the pharmacy profession and view it as essential (89% in one study) to the NHS and offering good patient service. Pharmacists were praised by politicians and in the media, while at the same time often feeling unsupported or mistreated by their employer. The PDA surveyed its member pharmacists in 2020 and a number of recurrent themes arose from their responses (some of which I have discussed above):

    - There was a distinct lack of PPE made available in all settings especially at the start of the pandemic; some community pharmacy managers discouraged wearing PPE and the quality offered was often poor or inadequate.
    - Some community pharmacy operators considered staff wearing PPE to spoil the aesthetic of their stores.
    - Although community pharmacies closed to the public for cleaning and for lunch, the workload expanded so much that many pharmacists reported working through the day without breaks.
    - Locum pharmacists reported no financial help when they were told to isolate or took ill with COVID-19 while the level of exposure was high.
    - Pharmacists reported many COVID-19 positive patients entering pharmacies, exposing them and their team to a higher risk due to staff not having PPE.
    - Serious medicine shortages were worsened by panicked patients stockpiling medicines in the early stages of the pandemic. This particularly affected inhalers used to treat asthma and COPD and the shortages were a major component mentioned in relation to the verbal abuse and threats suffered by almost all pharmacy staff.
    - There were numerous other issues which are dealt with below.

43. The Scottish Government has made a concerted effort across the NHS to support staff whose wellbeing and health has been affected by the pandemic. In 2022, the PDA was asked by the government to help publicise the National Wellbeing Hub directly to pharmacists and their teams. The Union welcomed this development because information that

was intended for these recipients had previously not always reached them.

44. Students had a particularly hard time, certainly in the first lockdown. In the second part of 2020, many suffered poor mental health after being locked down in their residences. I am personally not convinced there was enough support put in place by universities or by the government for them.

45. Many pharmacy students suffered poor outcomes during the pandemic. To become a registered pharmacist requires a four-year MPharm degree course followed by a Foundation training year, plus a final exam at the end of the fifth year.

46. In addition to opening a temporary register to allow recent retirees to recommence practice, the pharmacy regulator for Great Britain – the General Pharmaceutical Council - opted to cancel all in-person exams and allow the current cohort of 'pre-registration' trainees to enter the professional register on a provisional basis with some restrictions on practice, and later during the pandemic moved to online examinations. Pharmacy, unlike medicine, could not allow 'pre-registration' students to enter the professional register until and unless they completed the 'pre-registration' examination.

47. The pandemic disrupted all education institutions and hit hard those students who were nearing the point of registration into their chosen profession. It will be 2028 before an annual cohort that completes the five-year journey did not have some of their pharmacist education disrupted due to the pandemic.

48. Pass rates for pharmacists going onto the register have been dropping reflecting the disrupted education. Scottish pharmacy schools are also showing the results of disrupted education with black, Asian, and minority ethnic (BAME) students most predominantly affected.

Lack of Appropriate PPE and Risk Assessment

49. We ran out of PPE to sell to the public by February 2020 although the government were quick to say that people had to wear it. In community pharmacies, some managers were saying staff did not need it because it was only required if you were working with patients who were dying from COVID-19. However, people coming into community pharmacies did have COVID-19, so without masks, pharmacists were not protected.

50. In some of the corporately owned pharmacies, managers were saying people would be discouraged from coming in if PPE was worn by staff, that it set the wrong sort of image and was not attractive. In contrast, some pharmacies, if they had any, were giving PPE to patients as a

protective measure. There was also an issue of quality as some people were making their own PPE which were being reused even though they were dirty.

51. As early as 27 March 2020, the PDA wrote to Jeanne Freeman MSP, (submitted to the Inquiry) the Cabinet Secretary for Health and Sport, highlighting the lack of provision of PPE within community pharmacies and reported that most employers were not willing to procure PPE from alternative sources. It was stressed that community pharmacy was an important element within the entirety of the NHS.

52. Provision of PPE was very poor and frequently non-existent during the first period of lockdown. It did not even seem to be fairly rationed or distributed, and pharmacists reported that PPE simply turned up now and again, if at all, in a random fashion. The PDA believes that every pharmacist spent days without PPE or alternatively using and re-using masks for extended periods of time.

53. Some pharmacy staff had to buy their own PPE as there was none supplied by either the NHS or by their employer. Every day, government spokespersons announced in the media that there was plenty available in the system and that everyone in frontline jobs had access to appropriate PPE. That was not the experience of our members.

54. Some staff had to wear masks for several days. For example, I saw delivery drivers wearing the same mask for days because they only had one. At the same time, the guidance was that if you take it off you needed to replace it with a clean one. There was a real disconnect between what politicians were saying and what was going on. They were saying there are loads of PPE in the system but there clearly was not. It was a profound problem in the first lockdown. We were being told to wear masks into the autumn and on the radio, I would hear government ministers saying there were loads of PPE while listeners were phoning in saying "but I'm a doctor and we have none".

55. Certainly, in community pharmacies there was a feeling that as PPE became available, everyone else got it first, which negatively impacted staff morale. Things did start to calm down when we could begin to order it direct from the drugs wholesaler rather than the health boards, but people overordered because it did not always arrive.

56. The lack of PPE affected pharmacists in hospital settings too. There were concerns that they were not listened to by managers and some expressed a real lack of understanding and empathy. "There is significant amount of pressure to go to COVID-19 wards without any good PPE", said one pharmacist, "it's insulting for me that I am avoiding seeing my parents and living away from them to protect them yet

putting myself at risk at work because managers underestimate the risk of this virus."

57. A flavour of the scale of the shortage of PPE was given by numerous PDA members. Example quotes from practicing pharmacists include:

- "They did not provide any PPE; I was told not to wear a mask to protect business image."
- "Unable to keep 2m apart. Inadequate supply of PPE."
- "Short supply has to be reused, no proper disinfectant wipes to wipe down face visors or glasses."
- "Poor quality masks. Don't sit well on face, no tight seal and can't breathe while wearing them so no way we can wear. Shields far too tight so people with glasses are unable to wear as it doesn't leave room for glasses/spectacles."
- "Masks only supplied but told not to use them."

58. The PDA recognises that there was a UK-wide shortage of PPE in all settings and difficult decisions had to be made for the allocation and use of PPE.

59. The supply of PPE to pharmacists working in the managed sector, hospitals, and GP clinics was resolved as quickly as was expedient, but the supply to community pharmacies lagged behind. Pharmacists reported a lack of PPE even while government ministers and spokespeople were asserting the reverse on TV and radio.

60. The PDA also came across significant levels of poor practice in community pharmacies. Some pharmacy owners and managers restricted the wearing of PPE even when social distancing could not be properly observed.

61. There were also reports of locum pharmacists being instructed not to wear PPE they had sourced themselves. In contrast, there was other evidence of locum pharmacists being forbidden to use PPE provided to pharmacies, and given they were self-employed, they were told to acquire their own. There was no lead from the top in relation to masks although fortunately it all settled down in the end.

62. Another factor was patients having difficulties sourcing their own. We would get a delivery; these were for staff, but we didn't have any to sell to patients. Often, we would have to give some of our supply away to patients if they had none to wear themselves.

63. The PDA constructed a Risk Management Toolkit because of the calls and concerns reported by members. The toolkit was well received as it focused minds on risk and how this could be managed in community pharmacies. The problems with PPE were compounded because some

employers were slow to provide screening to protect pharmacy staff and patients, and to enable better social distancing in work areas. The toolkit was for staff use so they could go to their employer with best practice guidance. Once the initial surge in work between March and May 2020 started to abate, things began to settle down but problems that were evident early on festered until autumn.

64. There were discrepancies and a sense that the government was passing the buck and saying that decisions were being devolved down to the individual boards. We certainly saw that later in the vaccination process. When dealing with the health boards, organisations like the PDA had difficulties reaching the right people because the same job in one health board was named differently in another or departmental structures were different. There was an inconsistency of approach. When challenged, many would say that the government were not giving them a lead.

65. It was this confusion that led to the PDA producing a toolkit which was designed for use anywhere in the UK as everyone was experiencing the same risks. There were policy discrepancies between the four nations so we took the view that best practice in one should be best practice in all.

66. Community Pharmacy Scotland (CPS) brought out some guidance for Scottish contractors to use but ours was the only one that was comprehensive and applicable to all four nations. It meant anyone that had a concern could take it to their employer. Within the document, there was a note of government guidance which we wanted to reinforce, for example the 'one in one out' protocol was adopted in Scotland and so became best practice. However, adherence to risk assessment by some contractors was perhaps not as strong as it could have been.

67. PPE access issues were not resolved until late autumn 2020. There was PPE in July/August available to order but it would not always arrive.

68. In the initial stages of the first lockdown, staff were told by managers to continue to work as normal despite there being no masks available and no screens up in shops. This continued for several weeks, and some pharmacies were reluctant to put up screens because they thought it would be bad for business if people couldn't self-select products. In shops where there was no PPE, the lack of a screen became a serious problem for staff wishing to protect themselves.

69. In addition to the lack of PPE and screening, many staff suffered from cramped working conditions where social distancing was just not possible in practice. The space behind the counters is small and usually too narrow to socially distance. Even in larger pharmacies, the

dispensary is confined to a small corner, cramped and not conducive to any protection or distancing.

70. The lack of PPE, screening, cramped conditions, and inability to social distance all contributed to the very high levels of burnout recorded amongst staff by the PDA Safer Pharmacy surveys. Some staff refused to work, while some were at risk and so could not work.

Violence and Abuse from the Public in Pharmacies

71. The image that the public had of pharmacies, principally of community pharmacies because that was the only part of the NHS readily accessible to them, was one of utter calm.

72. This image was reinforced because for the most part during the lockdowns, patients had to queue outside and only one or a few at a time could enter. As pharmacy consultation rooms had to be closed due to the risks of COVID-19 transmission, many pharmacies operated on one-patient-only access to preserve patient confidentiality and to reduce the risk of COVID-19 transmission to other patients. People did not see the abuse or see the staff crying after patients were being aggressive towards them. It was very different to the reality. Friends and family would often say I was lucky to be going in to work every day and I would reply 'be careful what you wish for'.

73. The reality as reported to the PDA was somewhat different. Sadly, abuse directed at pharmacists is an ongoing issue, but during the pandemic many PDA members working in community pharmacies experienced significantly increased levels of aggressive and abusive behaviour from patients and carers. It affected all members of staff and varied from shouting abusive language, often of a racial nature, up to full physical assault. Many pharmacists had to report individuals to the police. The Union logged violent or very aggressive instances but there was a lot of general abuse. Sadly, I think this has continued. We now seem to live in a much crueller society. 95% or more of patients were really good but you always remember the ones who were unpleasant to you even though they are a small minority.

74. The following is a small selection of pharmacists' experiences:

- "Every day in different stores I had staff crying on me practically all the time because patients are being very verbally abusive and there's only so much good customer service you can give while people are harassing you left and right."
- "A patient verbally abused one of the dispensers, including verbal insults which involved swearing in an extremely aggressive manner. This affected the member and lead to tears."
- "Verbal insults have now become a daily occurrence."

- "It would be helpful if patients could be banned for this sort of behaviour, but I can't make decisions like this."
- "It should also be mentioned there are some amazingly patient patients out there and I genuinely appreciate their understanding. It's a shame some spoil it for all."

75. Results from a survey of more than 1,200 pharmacists conducted by the PDA in the first weeks of the pandemic and published on 14 April 2020 found that more than 90% of respondents had witnessed abusive or aggressive incidents in the past month. It also revealed that 80% of respondents thought that abusive or aggressive incidents had increased in the past month compared to normal levels.

76. The most common reported triggers for this behaviour were stock shortages, waiting times, queues, slow turnaround of prescription orders from surgeries, pharmacies closing for cleaning or lunch and demands for prescription deliveries to patients not designated as being 'at risk.'

77. Many people felt a loss of control and people were more prone to panicking. If, for example, you have a child with asthma and suddenly you cannot get inhalers, the panic is warranted. People were also angry about not being able to access their GP, not being able to go to work, or about what politicians were saying. They unloaded on us. Patients would panic about having to wait for two days for their medication, and about what would happen if it did not arrive. We were all experiencing an unprecedented situation, and if they felt politicians were not being honest, they would revert to the internet and to conspiracies. People were fearful.

78. People having to queue was a factor resulting in patients' anger. It was not so bad in the first lockdown (in the spring/summer months) but in the second lockdown (in wintertime) people were having to queue in the snow and the rain for an hour or more, and sometimes the pharmacist would not have what they needed. It was frustrating for everyone.

79. During the first lockdown, the abuse was largely because people didn't know what was going on. In the second lockdown during winter in January and February, it was dull and relentless, and everyone seemed down and on a shorter fuse. In winter it was rough. A lot of people died who are not counted in the numbers; those who were lonely and had mental health problems. I recall that each time I went to a pharmacy I hadn't been to for a while, I'd be informed about who had died. Not all of them were old or frail and not all had COVID-19.

80. The PDA has had a long running campaign to end violence in pharmacies, and as part of this, in 2017 it published a 'Stopping

violence in the pharmacy policy document'. This includes detailed information on the legal position, civil position, NHS position and professional position in relation to violence in pharmacies. The policy document sets out that patients can be barred from a pharmacy due to threatening behaviour.

81. The policy document and resource pack in relation to this will be provided to the Inquiry.

82. However, it was noted in a Pharmacy Network News article headlined 'Multiples urged to adopt zero tolerance abuse policy' on 14 April 2020 that PDA Director Paul Day had said "some employers have been reluctant to sign up to the PDA's long-running campaign on abuse as zero tolerance policies could lead to a loss in prescription income where a patient is ordered to take their scripts to another pharmacy."

83. The situation today in respect of violence in the pharmacy remains unchanged and many businesses are still reluctant to ban aggressive patients.

Issues for BAME Workers and Other Disproportionate Impacts

84. The pharmacy profession has higher than average numbers of female and BAME workers.

85. In 2019, the General Pharmaceutical Council (GPhC) reported that UK wide, 62% of registered pharmacists were female and 46% were BAME. The GPhC also reported that 88% of registered pharmacy technicians were female. Both groups were shown to be worse affected in a number of ways during the pandemic. We were not the only body attuned to this – the Royal Pharmaceutical Society reported on it at length as well.

86. In May 2020, the PDA wrote to Christine McKelvie MSP in her role as Convenor of the Equalities and Human Rights Committee, pointing out the increased risk to BAME people from COVID-19 and highlighting that a large proportion of the pharmacist workforce is BAME (46% UK-wide) (document submitted to the Inquiry).

87. The Office of National Statistics (ONS) published an article on 7 May 2020 stating that the BAME community were more likely to suffer a COVID-19 related death. On 11 May 2020, the PDA published this response:

"A significant number of PDA members are part of this community and provide front line services to patients, sometimes in the absence of appropriate PPE. We welcome the moves to start examining how we can better protect our BAME NHS workers, whilst in no way dismissing the ongoing serious safety issues affecting all key frontline workers who are

subject to heightened risks due to their inability to remain home during the lock-down.

We would encourage pharmacist BAME members, who have health conditions and are concerned regarding safe practice, to contact the PDA."

88. In June 2020, the BBC reported on a survey by the Royal Pharmaceutical Society (RPS) and the UK Black Pharmacists Association (UKBPA) which said that more than two thirds of BAME pharmacists had not had workplace risk assessments for COVID-19. The RPS-UKBPA survey also found that 78% of black pharmacists and pharmacy students felt they were at risk of coronavirus and wanted changes to be made to the way they work. The RPS called the results "shocking".

89. The issue was highlighted again to the UK government's All-Party Group on COVID-19 by the PDA in October 2020. It was also stressed that BAME pharmacy students were exposed to inequalities, and that changes to the registration exams disadvantaged many BAME students.

90. BAME pharmacists were subject to verbal abuse and violence, as were all pharmacy staff throughout the pandemic, but ethnic minority staff in particular were often subject to abuse of a racial nature. One reported that when trying to help a patient, he was told "your kind of people would not understand". It was a common theme, as was being told to "go home where you come from".

91. Many other pharmacists with protected characteristics also suffered impacts that were not dissimilar to many of these affecting BAME members. These include disabled and female pharmacists and messaging from the Union later in the pandemic took account of intersectionality affecting all these groups.

Poor Communication with Pharmacy Staff Not Directly Employed by the NHS and the PDA Response

92. There had always been communication problems between the NHS and community pharmacy staff, and COVID-19 crystalised these problems.

93. The Government and the NHS had to get lots of information out in a timely manner and they didn't initially, certainly not to all staff delivering services. To give the government credit, their due communication has significantly improved, lessons were learned and quickly addressed, and we are now in a much better position than prior to the pandemic.

94. In 2020, there were two conduits for health information relevant to pharmacy and pharmacists to be distributed. One was from the

government via the health boards, the other was through Community Pharmacy Scotland (CPS) – the pharmacy owners' representative body. The Scottish Government published clear guidance and information for all NHS staff. However, many of our member pharmacists reported receiving it late or not at all. The PDA received many complaints from pharmacists who never received or were unable able to access any important published information or guidance.

95. The health boards were good at getting the information to pharmacies, to the owners or managers, but the problem was that it often was not thereafter communicated on. It may, for example, have been sent to a manager who was not a pharmacist, or it may have been sent to an inbox seen only by one person. A lot of the information did not always get through to frontline workers.

96. CPS provided good and comprehensive information, but similarly staff sometimes found it hard to access it. Locums would go to one pharmacy and see the new guidance, and the next week they would be in a different pharmacy where the team were unaware of the updated guidance.

97. The key documents that the Scottish Government issued related to PDA members were HPS COVID-19 Advice for Pharmacies V1.0-V3.4 14/02.20 to 02/04/20 which was superseded from August 2020 by COVID-19 - Guidance for Health Protection Teams (HPTs). The superseding document covered primary care and the managed service distributed in the main platform by the health boards. A regularly updated series of 'Guidance for Community Pharmacy Staff' covering a variety of COVID-19 related subjects was distributed via Community Pharmacy Scotland.

98. Problems also arose around communications because not all pharmacy staff were able to acquire a 'nhs.scot' email address which was the primary conduit used by the health boards. NHS Scotland had updated its email platform in 2019 and there was difficulty issuing new email addresses to some staff, particularly locums. This affected the other medical professions as well. Consequently, locum pharmacists often never received the latest guidance at all because they often worked in different pharmacies and had no regular base.

99. The NHS email address situation has now improved, and all pharmacists have access to the email platforms and can register for health board dates as necessary. CPS have also opened up direct communications to any pharmacist who opts into their update service.

100. It must also be stated that communications disseminated by CPS were very comprehensive and were of good quality. However, for the reasons given above, they did not always reach all of the target audience.

101. The PDA published a series of news releases and documents in order to address the lack of information reaching many of our members, and also issued a series of guidance around clinical, contractual and employment problems. Many of the responses given were backed up PDA member surveys.

102. Many members consistently reported feeling 'left out of the loop' and, in response, throughout the pandemic the PDA produced a series of updates to members in order to counteract the ongoing communications failures described earlier. It communicated to members, from the start of the pandemic in March 2020, with a succession of newsletters updating them about issues, news, and changes of policy affecting them.

103. A series of updates were sent to all members, on risk assessments, government information, and relevant news from other sources. In April 2020, the PDA issued to all members a set of answers to Frequently Asked Questions. The PDA also campaigned on a host of issues raised by members. These include health and safety, infection control, PPE, testing for COVID-19, key worker recognition, NHS staff vaccination and ensuring that self-employed locum pharmacists were included in the arrangements. The PDA highlighted abuse from patients and customers, while contractual issues like indemnity, pay, sick pay and issues specific to our student members were raised and addressed.

104. Throughout the pandemic the PDA continued to issue updated summaries of the most important news and advice from all sources.

105. Finally, it must also be noted that since the pandemic, the Scottish Government's Pharmacy and Medicines Division has markedly improved engagement and communication with the PDA as a representative of pharmacists.

The Relationship Between Pharmacy Contractors and Pharmacists

106. Pharmacists and pharmacies are different things. Pharmacies are owned by contractors, shareholders, or companies, whereas working pharmacists are most often employees. This caused risk assessment discrepancies as an owner may take a different view to the pharmacists legally responsible for the operation pharmacy.

107. Many UK-wide and corporate community pharmacy businesses active in Scotland had difficulty constructing internal systems to cope with the difference in policies pursued by the Scottish Government and which were at variance with the other UK nations. This was frequently a cause of confusion among pharmacy staff.

108. There was frequent and contradictory instructions and advice issued to staff and patients throughout the pandemic by some of these UK-wide pharmacy chains, which was unhelpful. The confusion was compounded by mixed messaging in the mainstream media, both Scottish and the UK, and was detrimental to both pharmacist and patient's understanding. This was evident from the start of the pandemic and continued to the end of the pandemic period.

109. The PDA also received many reports from pharmacists providing evidence of failure by pharmacy owners to carry out risk assessments of premises or for staff. Some owners were also slow to put into place physical constraints of entry to pharmacies, or to enable social distancing or to ensure that patients and carers wore face coverings.

110. The PDA also received reports of some pharmacists testing positive for COVID-19 being pressurised by management to stay at their post until the employer could arrange for another pharmacist to take over and complete their shift.

111. The need to urgently self-isolate (due to COVID-19 or some other urgent unforeseen circumstance) potentially left some pharmacies without a pharmacist to supervise the safe dispensing or supply of medicines. A pharmacy cannot supply medicines when the pharmacist is absent. The regulator therefore permitted a specific time-limited dispensation where no penalty would be applied if, in specific circumstances, ready assembled medicines were being collected by patients in the physical absence of a pharmacist. There was a requirement for another pharmacist to be made available by telephone to assist the remaining pharmacy team during this short period of time. This action increased one major risk to patients (no pharmacist involvement) but mitigated against the risks of not receiving their medicines and becoming ill or having to make an additional journey to collect their medicines in the midst of lockdown.

112. However, almost immediately the PDA teams handled numerous calls from members asking for advice about some corporate owners making it a condition of allocating new locum shifts that locums should agree to supervise more than one premises remotely. The dispensation to allow supply of assembled medicines during the time limited absence due to illness stated clearly that an individual pharmacist must normally be present in the pharmacy and that a pharmacist can only be responsible for that individual pharmacy.

113. This also highlighted issues in relation to owners claiming they could not replace pharmacists, but in fact there were pharmacists looking for work. These companies attempted to run some pharmacies with no pharmacist present at all, with one pharmacist at the end of a phone

supervising activity, aggravating the most serious risk of all to patients, which is a pharmacy with no pharmacist.

114. This resulted in the regulator, the GPhC, issuing a warning to pharmacy business employers over their actions.

115. This attempted breach of the pharmacy regulations demonstrates that contractors should not have the final say on practice. In each pharmacy, someone is assigned as the 'responsible pharmacist'. If they are the only pharmacist, they decide if it stays open or not. There is evidence of pharmacy owners saying they would overrule this. There is no meaningful regulation of the management/owners of pharmacies, although there is strict regulation of the pharmacist. Inspections on the pharmacies themselves are also rarer – it could be every 20 years or so.

116. Pharmacy chains do however have a superintendent pharmacist who looks after every premise in the group, but only the 'responsible pharmacist' in a branch carries the responsibility if anything goes wrong. Responsibility that takes account of patient safety and clinical matters are paramount and must be put before commercial imperatives.

117. If staff were absent, big contractor pharmacies would struggle to fill the gaps and say there was a shortage of pharmacists, which would sometimes lead to pharmacy closures. However, the number of pharmacists were increasing year on year, and locums were not getting work despite being willing to. The figures in respect of the closures of pharmacies by contractors are spurious at best.

118. The number of closures of pharmacies was not caused by COVID-19, but it was caused by the practice of certain operators. Looking at the data, the majority of closures were attributable to two specific chains. Independent pharmacies did not close to the same extent and were able to mitigate staff absences. Health boards have documentation on the reasons for the closures. We publicised that this was happening at the start of 2021.

Reduced Wages for Locums, Statutory Sick Pay and Furlough Payments

119. Many recently retired health workers were encouraged to return to the NHS to support the system as it grappled with the impact of COVID-19.

120. The influx of recently retired pharmacists onto the temporary register held by the GPhC was used by many pharmacy contractors to drive down rates of pay and to cancel existing contracts with self-employed locums. Several employers cancelled shifts which were booked well in

advance because they had found a pharmacist willing to work for a lower rate.

121. Feedback from PDA members revealed that early in the pandemic some group owners cancelled large numbers of pharmacist locum shifts. One pharmacist asked for PDA support when they reported that they had two shifts cancelled with a national pharmacy chain, one at a rate of £30 per hour with full mileage, the other at £35 per hour with full mileage. Both shifts were advance bookings and were cancelled, and the following day they were contacted by a locum agency offering the same two shifts at £21 per hour.

122. Many locum pharmacists told us that pharmacy owners were taking advantage of the excess community pharmacist supply during the pandemic and offering the lowest rates of pay for many years. One said that "finding work was never an issue up until recently and this is greatly affecting my mental health, financially I have been hugely affected and I do not know how I will manage should the current trend continue." Another reported "averaging one day a week of work per six days availability. I've never known it to be like this, there is an excessively large oversupply of pharmacists in the community."

123. In contrast and despite the fact that several thousand retired pharmacists had returned to the pharmacy register across Britain, there was a sustained and vociferous campaign by some pharmacy owners and their representatives reporting alleged difficulty in obtaining locum cover for their pharmacies.

124. In the later lockdowns, some corporate pharmacy owners continued to turn away offers of work from locums and chose to temporarily close their pharmacies instead. This was to the detriment of patient care and was raised with the government, MSPs and in the press by the PDA.

125. Despite this, pharmacy closures have continued beyond the pandemic period and staff shortage is still cited as the major reason.

126. It must be noted that when these pharmacies are closed to patients, pharmacy owners are still reimbursed by the Scottish Government for services which they are unable or unwilling to deliver. This is in contrast with Wales, where they lose payments if closed and accordingly the rate of closure there has declined.

127. Another problem that affected Scottish based locums and reported to the PDA was that locum agencies and the UK wide chains brought in locums from elsewhere in the UK. These locums took block bookings at lower rates but were unable to deliver the full range of Scottish pharmaceutical services required by the government, and which

Scottish pharmacists had undertaken considerable training in order to provide and they had not.

128. Pharmacy First (the system under which pharmacist can deal with and prescribe for certain ailments to reduce pressure on GP practices) and many other extended services supplied under NHS patient group directions were therefore denied to some Scottish patients at a time when access to other parts of the NHS was being severely impacted.

129. In summary, wages for locum pharmacists were reduced and because all holidays within pharmacies were initially cancelled due to the pandemic, many locum shifts were cancelled. If locums were unable to secure shifts, they received no salary/income and as self-employed contractors were not entitled to benefits or furlough payments.

Pharmacist Payments for Involvement in Vaccine Sessions

130. Once a vaccination against COVID-19 had been developed, there was a significant nationwide campaign to vaccinate those most at risk due to their vulnerability such as those with existing health conditions and high-risk age-groups. Many pharmacists, particularly locums, volunteered to work delivering vaccine sessions in the push to get widespread coverage as soon as possible.

131. The government sought to identify health professionals for priority vaccination via their employers, but locums do not have an employer. The PDA created a web portal where any locum, whether a PDA member or not, could register their details and location and then the PDA provided lists to each Health Board of those that were being missed by the employer-based cascade.

132. Pharmacists are healthcare professionals with long experience of providing flu vaccinations to the public in community pharmacies and many pharmacists are accomplished vaccinators. In 2020, I personally had been giving flu jabs for 15 years.

133. In anticipation of contributing to the vaccination rollout, many locums had bought additional indemnity insurance, undertaken specific training, and received Hepatitis-B vaccines where appropriate. They were also training others in vaccination. In the COVID-19 vaccination programme pharmacists provided support and training to both the optometrists and the dentists who had joined a vaccination programme for the first time.

134. They were then excluded from the vaccination process because of business imperatives. The communications members received relaying this was a slap in the face for locum staff. The NHS did not save any money doing it this way, but it did mean the payment did not go to the pharmacists doing the job, but instead it was paid to the owners of the

pharmacy businesses. We felt strongly that it was wrong. One phrase used in multiple emails from health boards to PDA members cancelling their agreed arrangement was that "*The Pharmacy Contractors are uniquely placed to balance participation in the vaccination programme with ensuring patients have continued access to the essential pharmaceutical care services and their own business needs.*" Members queried what is meant by the "business needs" of these private employers.

135. Greater Glasgow and Clyde Health Board (GGCHB) had offered sessional rates of £69 per hour to pharmacists, optometrists, and dentists. Many contractors and locums offered to participate, and all were initially entitled to the same rate of pay. Due to flu vaccination campaigns pharmacist were most likely to be the most experienced in giving upper limb vaccinations.

136. The system for booking vaccination shifts was very similar to the locum booking system and pharmacists were therefore very familiar with the system, so they booked themselves into sessions. Some other professionals were perhaps not so good at using the platform and so had booked in for less shifts.

137. Subsequently and unexpectedly, government guidance was issued on 5 March 2021 to the effect that locum pharmacists should no longer have the option to provide the service at that rate. All the pharmacy contractor groups (the pharmacy owners) and only optometrist and dentist locums would be entitled to payment at the previously agreed rate.

138. Only community pharmacist locums were excluded and subsequently sessions were then re-offered back to them at £14.50 per hour.

139. The new guidance ensured that community pharmacy contractors were to be paid the £69 per hour rate if they supplied one of their employee pharmacists to undertake the activity. Any difference between the £69 per hour fee and the lower cost of providing a pharmacist was retained as profit.

140. The PDA met with senior civil servants in Scottish Government and contacted the Chief Executive of Greater Glasgow and Clyde Health Board (GGCHB) seeking answers to why only locum pharmacists had been singled out for this treatment.

141. Discussions with government representatives indicated that they had considered the "business needs" of pharmacy contractors, and it was suggested that if many locum pharmacists gravitated towards the more lucrative vaccination service it would denude the supply of locums. It

remains unclear to the PDA where the evidence was that supported this scenario. In fact, a survey of PDA members based in Scotland indicated that many locums had reduced work at this time.

142. In GGCHB's replies, the PDA was told "*the deployment of locum pharmacists is essential to maintaining the full range of current pharmaceutical care services, such as the dispensing of medicines or the provision of healthcare advice or treatment. To ensure this is the case, the guidance advises that sessional rates can only be offered to the pharmacy contractor*". A copy of this letter will be provided to the Inquiry.

143. The PDA understands that the decision to remove those locum pharmacists slowed down the vaccination rate.

144. The priority that this Scottish Government policy gave to the interests of business owners, some of whom are large multinational companies, must be questioned. This was a policy development distanced in its discussions from the representatives of the individual pharmacists who wished to contribute to the national vaccination effort.

145. This issue highlights a much wider concern about Scotland's pharmacy arrangements. When the PDA asked its members who they thought was responsible for the exclusion of locums, almost 70% of respondents said that they believed that certain community pharmacy contractors or their representative body, CPS, was responsible.

146. The PDA was never aware of any pharmacist shortages in Scotland at that time and the explanations given do not stand up to scrutiny.

The NHS Staff £500 Bonus Payment

147. Often community pharmacists are not considered to be part of the NHS and the difficulties that arose from the Scottish Government's bonus payment was a classic example of that. Many pharmacists in community were initially denied the NHS bonus payment of £500 on the spurious grounds that it was only to be made available to staff directly employed the NHS. It was given to all NHS staff, whether patient facing or not. Nobody was more patient facing than community pharmacists and it was subsequently agreed they would be paid too.

148. In March 2021, the PDA raised this matter with the government, and it was agreed that locums would also be paid. However, problems rose for locums attempting to claim the bonus given they contract to multiple businesses.

149. CPS members, businesses who are not the employer of locums but are their clients on a shift-by-shift basis, were asked to collect the details of

their staff and made the claims on their behalf. However, many CPS member pharmacies were unwilling to organise the claims for locums, as a result of which, most locum pharmacists had difficulty making a claim.

150. While some contractors were willing to do so, the communication problems (detailed above) meant instruction on how to register arrived with many locum pharmacists after the deadline to make claims had been passed.

151. After months of correspondence between the PDA and the government, a web portal was finally created to assist locum claimants. The PDA publicised the portal and informed members that claimants would be paid by the end of August.

152. However, the process was flawed and unnecessarily cumbersome and the level of detail and checking required was overly bureaucratic. When the payment was made to each of these key workers, it arrived up to six months after other NHS workers. Many pharmacists who claimed on time were not paid by the end of August.

153. The PDA set up an interest group and supported several members with an outstanding claim, including one pharmacist who missed the claim deadline because she was on maternity leave. Also, the claim form was designed for those locums who worked in community pharmacies. We were informed of one pharmacist who had fulfilled a seven-week locum in a hospital during July/August 2020 and had applied through the government portal, only to be blocked when asked to supply a four-digit community pharmacy code in relation to her place of work, which was not possible.

154. Many PDA members felt that they were not trusted to make the claim, one wrote, "I have been advised that I will get my payment once the finance team complete their assessment and they are happy the claims are completely accurate. You will be contacted directly by them to discuss your individual claim as we are unable to discuss that with you".

155. The portal set up by the government was not user friendly and the difficulties encountered accessing the payment left many locum pharmacists feeling dislocated and excluded from the NHS core. Many locums and PDA staff were left feeling distrusted by the tone of questioning used by the NHS staff they had contact with.

156. We suspect about 30% of pharmacists working in community pharmacy are self-employed and work between one and five days per week. A large number of people were therefore affected. All were left with a sour taste in their mouths. It reinforced a message that they are not part of the NHS.

157. Community pharmacies don't receive many of the same benefits as NHS staff because of their employment status, and this applies equally to those who are employed and self-employed.

The Status of Community Pharmacists Within NHS Scotland

158. All sectors of pharmacy suffered multiple and unforeseen problems during the pandemic. It must be recorded that pharmacists everywhere and in every sector rose to the challenge often knowingly risking their own health to be part of the national response to a pandemic and to care for their patients.

159. Even during the strictest of pandemic lockdowns, it was only community pharmacies that were freely available to the public to access for advice and help. GP surgeries typically remained open but only for booked appointments and even then, no face-to-face appointments were available unless it was essential.

160. Yet, there remains evidence of an underlying attitude that community pharmacy staff are in some way not thought to be 'part' of the NHS. No doubt this contributed to community pharmacists being considered as lower priority at many points during the pandemic from the initial distribution of PPE onwards.

161. It would help if all individual community pharmacists were recognised as professional clinicians who deliver taxpayer funded NHS services to patients, just as their professional colleagues employed and deployed by the NHS in GP surgeries, hospital, and other support services are.

162. The pandemic experience has highlighted that an institutionalised over-reliance on the representatives of pharmacy owners to cascade information and resources, ensure the provision of PPE to staff, organise vaccinations, and distribute bonus payments often excluded locum pharmacists by default. Their commercial objectives were often the priority. Direct NHS communication to these health professionals could have mitigated against many of the concerns and problems that were reported to the PDA, and thankfully these communication issues have been addressed.

163. Further, while individual pharmacists know they can potentially face career ending consequences if they fail to comply with agreed professional standards policed by the pharmacy regulator, PDA members recognise that community pharmacy owners are not subject to the same level of scrutiny.

164. The PDA believes that the GPhC as a regulator and NHS Scotland as the commissioner of the community pharmacy services need to do more to

ensure the appropriate behaviour of pharmacy owners. For example, what consequence was there for the employers who failed to protect staff by denying them PPE because it was "bad for business", or the one who had a confirmed policy of allowing COVID-19 positive staff to treat patients, or any of the other instances described above?

165. The benefits of an NHS touchpoint providing 'open without appointment' access for advice, even for those not yet registered with a GP, relieves pressure pinches on the wider NHS all the time. It became even more critical during the pandemic.

166. NHS Scotland must learn lessons from the pandemic experience and properly incorporate every individual community pharmacist into the wider health system.

167. Our view is that it would be better that pharmacists work for the NHS and are able to take a purely clinical view rather than be subject to commercial interests. In Scotland, there are approximately 1,300 contractor run pharmacies and approximately 6,000 pharmacists. Yet, there are only 100-200 pharmacists at director level in pharmacy businesses. The contractors' body does not represent a high percentage of actual pharmacists.

168. The NHS requires prescribers that can specialise, and these pharmacists should be employed by the NHS so that their priorities can be set based on patient needs, not commercial whims. COVID-19 highlighted the dislocation that exists, and this has to change. In GP surgeries, the pharmacist can be employed by the NHS or by the surgery, but the priorities are often different between each practice and health board. Covid has highlighted these difficulties.

Shortages

169. The first shortage we encountered was of paracetamol products. Stocks ran out very fast because it was something that patients could buy without prescription and stockpiling occurred. The tabloids were saying that colds were similar to COVID-19. A number of viruses cause the common cold, some of them being coronaviruses, albeit very different to COVID-19. It's a useful drug and good for fever, but initial press coverage did not help.

170. There were also shortages of anything to do with breathing, like inhalers. Certain antibiotics were also short – the whole supply chain was completely disrupted by the onset of COVID-19, factory to pharmacy.

171. Other shortages were caused by people stockpiling. If people had stockpiled as much as they did, logic suggests you would experience a

late dip in demand as patients would already have been supplied excess medicines, but there never was one. This suggests there was probably a lot of waste due to overprescription in the early stages. Other ongoing shortages were caused by commercial/supply chain factors because production and distribution were disrupted globally. While I'm not sure BREXIT was as much of a factor then as it is now, supply issues must have been made worse when the UK left the EU after Brexit.

172. All of the gloves, masks and hand sanitisers were gone before we realised there was a problem, especially masks, which disappeared very quickly. That shows how little there was in the supply chain.

173. Very quickly pharmacies began to run out of cleaning agents and couldn't get more in. This was at the start of March. We were told that everything was withheld for use in the health service.

174. By mid-March nobody had any masks or stock. There were perhaps one or two people who had a box here and there and obtained from Amazon. Within community pharmacies, staff assumed that the NHS must have stocks, but I believe everyone was in much the same position. There was a total sense of unpreparedness in this regard.

Pharmacy First

175. Pharmacy First was implemented during the pandemic. It was due to be rolled out April 2020 but due to the pandemic, this was pushed back. Pharmacists would not have coped with the rollout in April 2020 given the explosion in demand for services. The new scheme was instead rolled out on 29 July 2020.

176. Before the pandemic, Pharmacy First was known as the minor ailment scheme (MAS). There were a lot of initial trials and different versions of it with pilots began around 2002. In 2016, MAS was introduced. MAS was a national scheme that enabled supply of many pharmacy-only medicines against a formulary and introduced a list of Pharmacist Group Directives allowing prescription medicines to be supplied by pharmacists. These were supplied to patients free at the point of need. The intended 2020 rollout was a significant change to MAS, and it required substantial training.

177. The concept behind the scheme is that pharmacists can treat certain ailments and illnesses without the need for a GP. These are conditions like hay fever, fungal skin infections, UTIs, some bacterial skin infections, shingles. It means more consultations are required. COVID-19 made it all the more difficult and extreme given pharmacists were already under pressure to take on more consultations (as outlined previously).

178. The Pharmacy First service was particularly well used because people couldn't get to the doctor in the first place. It has continued to be widely used to date. It must be considered a very successful development and was certainly of great help to patients during the pandemic. It was announced in August 2022 that in two years, Scotland's pharmacists had undertaken over three million consultations under the service.

179. Some services couldn't be continued as before, for example the stop smoking service pharmacies can offer. It requires patients to blow into a machine to monitor their carbon monoxide levels while they are using nicotine replacement therapy. That had to stop during the pandemic.

180. There was an expectation pharmacy staff could help even when we couldn't assist, and that probably was compounded by the fact that the only part of the NHS that patients could access easily and without appointment was a community pharmacy.

Rollout of Vaccinations

181. We received telephone numbers so that we could book ourselves in for vaccinations. It was handled quite well aside from perhaps isolated incidents. But by and large, all pharmacy staff who wished to have the vaccine were able to do so without difficulty.

Long Covid

182. We have no data on Long Covid that might be useful to the Inquiry other than to confirm that we understand it is a severe illness. One of the main difficulties from a work perspective was around employment difficulties this presents for members. The PDA deals with these on a case-by-case basis and is grateful that the Scottish Government have recognised Long Covid as a specific illness.

183. Furthermore, the Union supports the STUC campaign to have Long Covid treated as an industrial injury and is supportive of the work and assistance of Long Covid Scotland.

Addiction Services

184. We think pharmacy addiction and drug substitute services continued to work well during the pandemic. The relationship with drug users and pharmacists tends to be very good. Most patients are well managed and because pharmacy staff see them several times a week, good relationships are the norm.

185. Addiction services during the pandemic worked quite well for those who took replacement drugs because patients were only allowed one person

on the premises at a time, so it worked well for confidentiality. The 'one in one out' system served them very well in that regard. The major problem was that many were on supervised consumption so had to consume on the premises at the counter because we could not use the consultation room. Many of them are very small, sometimes just an adapted cupboard with no windows and no ventilation.

186. There are varying levels of support required for treatments. With methadone and buprenorphine, it varies – some people were consuming daily on the premises, some three times a week and some consume at home. When these patients tested COVID-19 positive, thus confining them to home, arrangements were made for their support workers to collect their medicine. In some cases, pharmacy teams delivered medicines to these patients subject to risk management protocols for their delivery drivers.

187. The only time there was ever a problem was when a pharmacy had to close suddenly and didn't manage to inform the patients. There was a worry that if these patients couldn't get their daily dose, they would find sources elsewhere on the black market.

188. The problems experienced were not significantly different to those experienced before or after the pandemic. There was no major disruption to the drug replacement services and, in many ways, these specific patients received the same treatment as before.

189. I personally never experienced carers or support workers picking up large batches of prescriptions for patients. Sometimes social workers would collect for patients who had COVID-19 and pharmacy delivery drivers would deliver as necessary.

Contraception EHC, Sexually Transmitted Diseases (STD) Treatment and Unscheduled Supply

190. We did not note any difference to these services.

191. Scottish pharmacists are authorised to provide an 'unscheduled supply' of nearly every medicine listed in the British National Formulary if there is a need, and this includes contraceptive drugs. The main exceptions are the opiates restricted by the Misuse of Drugs Act. This did not change.

192. By way of explanation, we can supply if we are satisfied the patient has previously been prescribed the drug and is for whatever reason, is in urgent need of it. We can contact their surgery or check the emergency care record or phone their usual pharmacy to check if necessary. Unscheduled care was used a lot during COVID-19 because of constraints on the GP surgeries. We cannot supply controlled drug medication and would only supply drugs used in acute care like

antibiotics in exceptional circumstances. The pharmacist making the supply is required to inform the patient's GP that they have done so.

193. Provision of EHC (Emergency Hormonal Contraception) through a community pharmacy is covered by a national protocol and was not affected by COVID-19. Similarly, some health boards have local protocols for the supply of STD treatment and to my knowledge, these too continued as before.

194. For anything else we could not prescribe or supply, we would signpost to the relevant service. The health boards were good at signposting these services.

Geographical Differences

195. We think things were very similar everywhere. There may have been small differences, but I don't think even in the islands there were huge differences as far as pharmacies were concerned.

Lateral Flow Tests (LFTs)

196. When LFTs were made available to the general public, we were aware of some people going to multiple pharmacies for multiple test kits, but you couldn't really refuse them. You couldn't prove they already had them although we suspected many of them were stockpiling the test kits.

197. There often appeared to be plenty of LFTs but then we would sometimes run out. The distribution chains must have been stretched to the limit. There was initially a record keeping component of people being provided with test kits using patient management records (PMRs) in the pharmacy, but we saw so many people that weren't our patients and not registered on our PMR that it became a major time problem as we had to input full patient details. The recording system was very onerous and eventually had to be suspended. It was easier just to swamp the market in the end.

198. I noted no difficulties with expiry dates on LFTs once they became readily available.

Childcare and Homeschooling

199. Childcare was an issue for a lot of our members.

200. This could be a particular problem in more rural areas. If, for example, you worked in Jedburgh but kids had to go to Kelso, it was problematic for getting them there and picking them up. It wasn't as big an issue in cities.

201. However, homeschooling was an issue if both parents were key workers, particularly if it meant one parent couldn't work. If they couldn't get furloughed and they can't work, where do they sit with their employer? We were aware it was a problem for a few individuals.,

Scottish Government Consultation Groups

202. CPS were part of these groups to represent pharmacies and (they claimed) pharmacists. The PDA were not part of that process.

203. We engage with the Fair Work Convention which requires that workers have a voice. We say that the CPS cannot represent working pharmacists and that we, the PDA, are the appropriate body for this. CPS do not specifically represent pharmacists because they are the representative body for owners of pharmacies.

204. PDA were not involved in any of the groups creating guidance etc, but we should have been and expect to be in future. The PDA's relationship with the Scottish Government is much improved since the pandemic If there were another pandemic, it would not be a case of 'if' we were involved but 'how' and 'where' the PDA would be involved.

Lessons Learned

205. There were some positive outcomes from the pandemic. One positive was the improvement in communication between the government and pharmacies.

206. COVID-19 also led to us, the PDA, internally devolving focus to Scotland. We have a much better understanding of Scottish Government and vice versa. Communication is much better and the ability to go to the government about pharmacists' concerns is much improved. It used to be the case that we chased them, but now they contact us too to discuss matters.

207. One thing you see a lot more of post pandemic is that pharmacies are more willing to close at lunchtime. It suits the staff much better; they need rest breaks too.

208. The standing of pharmacists in the community has also improved. It has not been lost on the public that only the pharmacies had their doors open, and that you can consult a pharmacist without appointment.

209. What should be done differently is preparation before the event. PPE should have been in place, but much was out of date when it came to be needed. Contingency planning requires planning before the event, unforeseen or not. It should be mandatory and should encompass all

parts of the NHS, including those areas where services are delivered by private contractors.

210. GP surgeries should have continued to be more open, as the sudden wholesale closure meant too much responsibility and workload was pushed onto community pharmacy teams.

211. I personally believe pharmacists should be employed by the health boards and not by businesses. This would best enable pharmacists to deliver NHS services on the basis of patient need. I don't believe any professional clinician should have their practice influenced by commercial factors.

Hopes For the Inquiry

212. I would like to see lessons have been learned and for the truth come from this Inquiry, not a whitewash or a fudge. I don't think anyone who worked during the pandemic should be treated as special for what they did. None of us are heroes, the staff who worked did so because that was their job and if they didn't do it, who could.

213. Many people did good things simply because they do good things, and although it is not always hard it is certainly not always easy either. It must also be remembered that outside the health service, many other people did a lot to help. The workers in the wholesale distribution network, community workers and volunteers and the retail workers who kept us fed.

214. I would like the pharmacists' story to be told, because I think it is an interesting one, and one that was not always visible at the time.

STATEMENT CONCLUDES

Signed: Maurice Hickey

Date: 02nd May 2024

This is my final statement to the Inquiry.

By typing my name and the date below, I accept that this is my signature duly given.

Signed: Maurice Hickey

Date: 02nd May 2024