Appendix xiv: LPC national survey data analysis

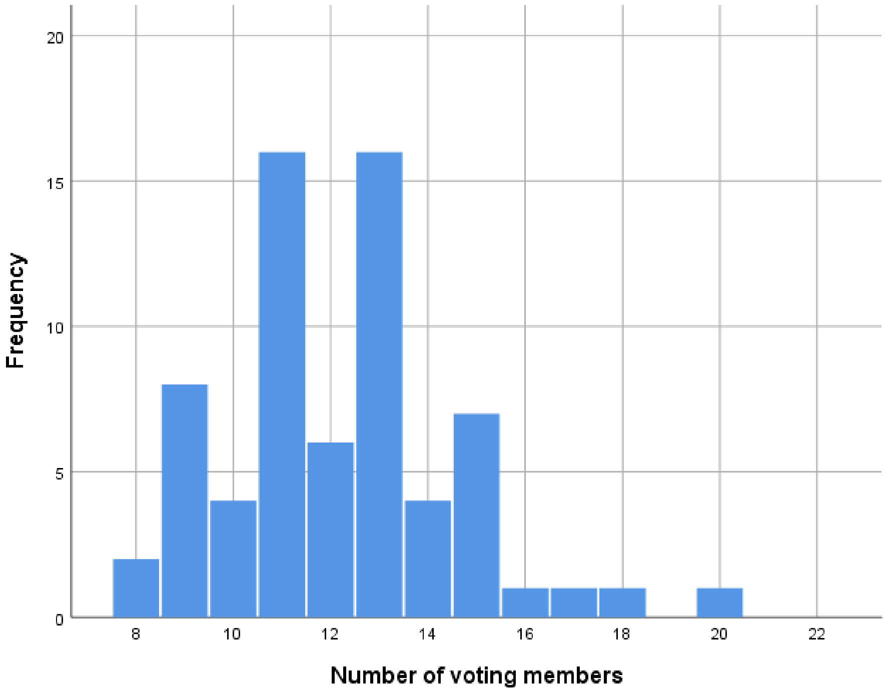
Notes for interpretation:
Most committees reported a process for gathering views from the committee and reported the number of people (and affiliation) that managed to feed into their response. There were some very lengthy responses to some of the questions that contained lots of detail and caveats. Where there was disagreement between particular views on the committee, this was referenced and the various viewpoints explained. The results will be discussed by survey section.

68 out of 69 LPCs completed the survey, all giving permission to use the data for analysis. Reporting is arranged according to the sections of the survey. The main comments from the open-ended responses are summarised as bullet points throughout.

Section 1: About your LPC

The number of voting members reported on LPCs is summarised in figure 1. The mean (SD) was 12.2 (2.4).

Figure 1. Number of voting members on local pharmaceutical committees



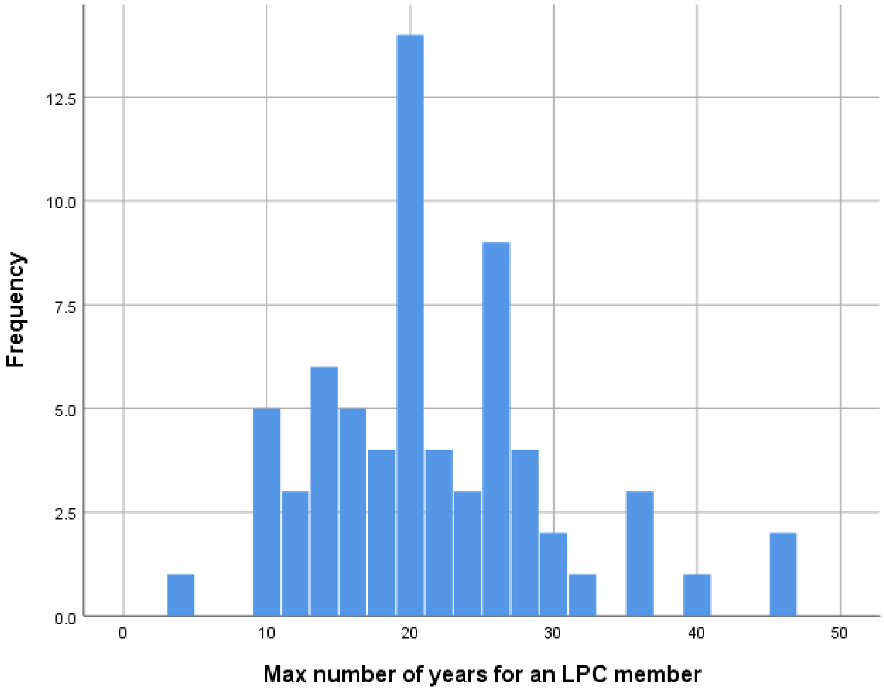
51 (75.0%) reported that all members had been involved in developing their response. Most described the nature of the discussion and that various position papers were circulated to all members prior to finalising a response. The effect of this was that where disagreement between committee members was unresolvable, many chose to upload comments that represented the different positions.

In terms of the size of the committee, this LPC captures the general mood: “we had 13 before the last elections and reduced to 9 to allow more support from our employed team to undertake the work of the LPC more effectively as capacity of LPC Members is an issue” and another LPC commented: “A potential committee size of 7-9, potentially covering a wider geographical area was mooted by CCA members. It was recognised that discussions within such a sized group are productive (noting the effective flow of conversation in a 7-member team at this meeting).”

There are some LPCs that refer to the need to have more members in order to account for absences and some that think more members is good as it allows the work to be spread more evenly across the committee. Non-attendance at meetings was seen as a problem that currently appears to be addressed by having more members on the committee. A small number of responses indicated that a committee needs to have sufficient numbers in order the members can engage with external stakeholders. However, there were other respondents who highlighted that this should be the job of the employed officers and not the committee as part of their rationale for reducing the overall size. A number of responses highlighted the need for the committee to be of sufficient size to represent a) the number of contractors and b) the diversity of contractors within a given area.

15 (22.1%) reported having a current PSNC member on their LPC with 6 (8.6%) reporting a previous PSNC member. The maximum number of years current members have been on their LPC is provided in figure 2. The mean (SD) maximum number of years was 21.3 (8.3). 65 (95.6%) of LPCs did not believe that there should be a maximum term of office for committee members. It was felt that the current absence of a maximum term is appropriate providing that there are measures to capture engagement and contribution, as one committee put it: “we can’t have any passengers”. Numerous comments relating to committee membership based on “competency, skills and willingness to give” and the need to have a balance between experience and new blood. There were also a small number of interesting comments about succession planning and encouraging contractors to become “members in waiting”.

Figure 2. Reported maximum number of years on LPC



LPC committees meet at least five times per year up to a maximum of ten times (approximately every month except August and December). It appeared that these meetings were full-day although not all respondents specified this.

The mean (SD) length of chief officer employment was 8.3 (9) years (range 0-36 years). 64 (94.1%) believed that there should not be a maximum time period for chief officers. Most LPCs strongly suggested that there should be a clear performance management process in place and governance structures that could address poor performing chief officers. There was a recommendation of an initial five-year fixed term contract for chief officers however some suggested that this would reduce their ability to recruit high quality candidates and may lead to “lazy way to performance manage”.

55 (77.9%) reported that the chief officer could not be a member of the committee. The majority view was that the chief officer should be a non-voting member/not a member to ensure good governance and avoid conflicts of interest.

58 (85.3%) stated that the selection of chief offices should be standardised. Suggestions included a standardised person specification template that could be adapted by each LPC depending on their needs for the role: “The process should be standardised in terms of transparency around recruitment, for example external advertising of positions, documentation around shortlisting etc. However, while the person specification may have some shared standards it is not practical to have a common person specification for all LPCs as the structure, skills and knowledge of the rest of the team may be a factor.” Some respondents commented on a job description rather than a person specification.

One response captured the common the elements that may be included in a person specification: “Local knowledge, community pharmacy and NHS knowledge, organisational skills, leader, networking, teamworking, work ethic, experience, business knowledge, proven track record in leading a team, negotiation skills, emotional intelligence, goal setting, influencing, managing people, communication, conceptual thinking, above average intelligence.”. This respondent went on to say: “Not essential to be a Pharmacist, more important to be the right person.”.

With reference to the inclusion of non-contract holders to the LPC committee, respondents views split into: a) no, you must hold a contract to be a member of the LPC, b) they cannot be members with voting rights but should be encouraged to attend meetings and feed into discussions or c) they should be allowed to be voting members of the committee if they have certain skills, “enthusiasm” or knowledge that are important. However, this last option was in the minority as most felt that voting rights should be reserved for those with a contract. There was also a recognition that a significant number of committee members are present to represent contract holders rather than holding a contract themselves.

42 (61.8%) believed that the LPC should reflect the diversity of its contractors and contractor representatives. This was viewed as difficult given that a proportion of the committee are elected (from people who nominate themselves) and the remaining proportion are nominated. Overall, there was a feeling that members of the committee should be appointed based on merit and their ability to do the job. A small number of comments related to making meetings more accessible so that local contractors (from all backgrounds) feel able to engage with the activities of the LPC.

Thoughts on the number of contractors represented by LPC and how they see this size changing in the future:

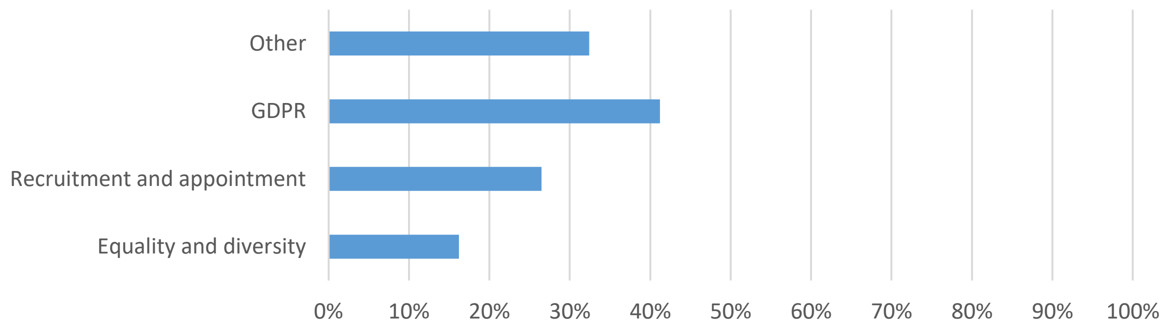
- The majority of comments thought that the current size of LPCs was appropriate and allowed them to function well.
- Recognition that geography (physical and NHS & LA structure) were important in making decisions about size with particular reference to STP/ICS sizes.
- Can’t go too big as you will lose local relationships.
- An LPC with c.200 contractors stated: “We believe this number of contracts enables us to be effective – big enough to work efficiently with stakeholders but small enough to be known by and to support individual contractors.” with another (c350 contractors) suggesting that this number is “close to perfection”.

- Most see a reduction in the number of LPCs but there is no coherent number with most comments relating to the pros and cons of the '300' figure and the need to base the final number on the points above not a random number.
- Many LPCs commented on plans to merge, federate or share services and staff that would result in a contractor base in the region of 250-350.
- Many LPCs commented on the benefits of a more appropriate size and footprint: "Efficiency (enabling the employment of a team to undertake the operational activity of the LPC). Single voice with a commissioners within the [local] system – avoiding mixed messages from different LPCs. Good brand identity – commissioners know who to contact to discuss community pharmacy, single point of contact"
- A small number of LPCs referenced the level of the levy: "Currently this feels about right, this is reflected in our relatively low levy."

44 (64.7%) shared functions with other LPCs. Many LPCs described sharing agreements (whether formal or informal) in terms of staff, communications or training. Some LPCs reported no shared functions but described sharing best practice/ideas.

Figure 3 shows what LPCs reported routinely monitoring within LPC members for up to date training completion. There was broad agreement in the responses that as non-employed members of the LPC, the committee received their training through their employer. Some LPCs described capturing this information. Most felt as though this training should be provided via the PSNC and could be covered during the 'New Members Day'.

Figure 3. Routinely monitored for up to date training within LPC members



Section 2: LPC roles and responsibilities

In summary, most LPCs indicated that providing training to support the implementation and delivery of national and local service along with changes to the contract as part of their role. Training related to leadership, clinical and management skills was not seen as part of the role.

In terms of other roles the LPC should be providing, the most important included negotiating local services, supporting innovation, representing the community pharmacy voice to PCNs and other local organisations. Those that received the least support included contract monitoring and ensure contract claims. Free text responses on this theme included the thought that LPCs should be "supporting contract claims rather than ensuring" them and that "optimising contract delivery is a national role".

Figure 4 shows what LPCs believed contractor funds should be used to support. Additional comments included:

- Many responses indicated that the LPC should not provide any other training from levy funds

- LPCs should provide local training from levy funds only when it applies to all contractors. These funds should be obtained from the commissioner.
- The appropriate body needs to deliver the appropriate training e.g clinical skills – CPPE, leadership – contractor themselves.
- LPC supported but not contractor funded was a common theme.
- LPCs should not provide training that is within the remit of individual contractors
- "In order to be fair to all contractors, training should either be funded from external sources and open to all or paid for by contractors individually"

Figure 4. Support services which should be provided for from the contractor levy

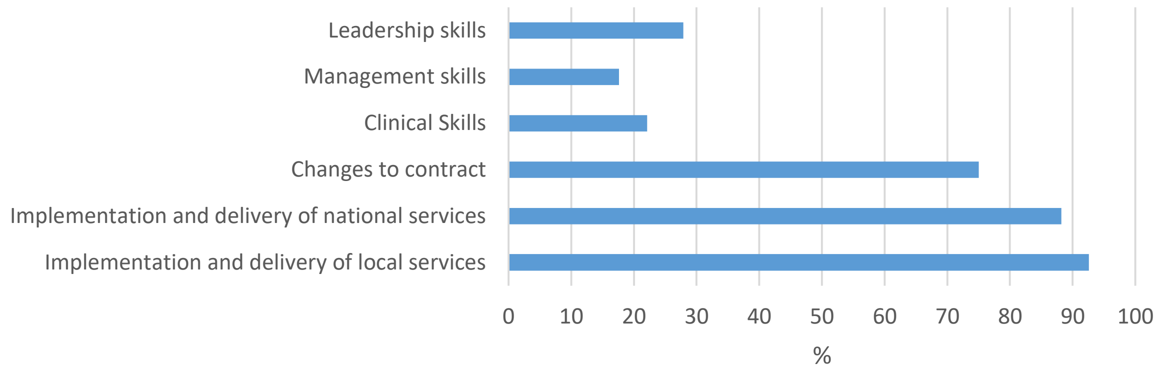


Figure 5 provides a summary of LPC views on the importance of different roles it can potentially undertake. Other roles and comments identified by LPCs included:

- National priorities need to be funded nationally and not from levy
- Supporting local relationships and innovation in LOCAL services
- Local digital integration – often cited in responses as CCA view
- Some comments about PNA, contract entry
- Pastoral care to support contractors e.g. mentoring
- "Supporting contract claims rather than ensuring."
- "Optimising contract delivery is a national role"
- "Not supporting independents would leave them vulnerable"

Things the LPC can do differently to support contractors:

- Focus on 'local' and building relationships
- Collaboration with PCNs and working more closely with them
- Narrower remit for LPCs
- Mentoring/coaching support for contractors, support for developing local leaders
- Working collaboratively with each other, PSNC and contractors (better communication)
- Lead change in behaviour
- Better use of technology
- Transparency – improvement required – demonstrate work leads to tangible outcomes

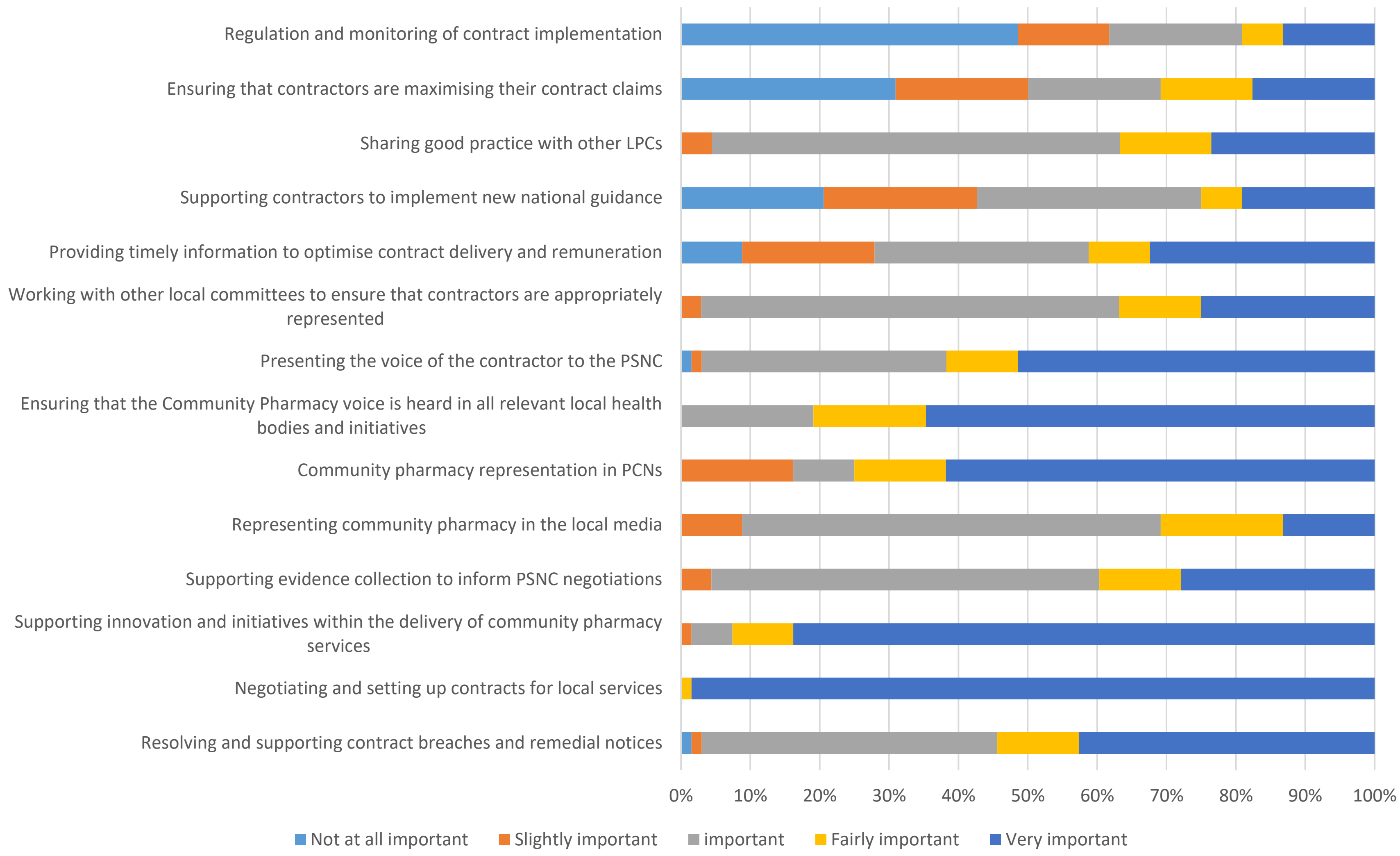
A variety of non-levy income sources were cited by LPCs including those from:

- HEE
- NHSE&I
- Industry
- AHSNs
- PharmaOutcomes
- LPNs

- CCGs
- Local authorities
- NHS Digital
- Range in value from c. £20K per annum to c. £1m over the last few years. Wide variation observed in amounts and funding bodies between LPCs.

LPCs were asked to identify examples of good practice with respect to support. Rather than solely identifying good practice, many LPCs highlighted the work that they do for their contractors on a more general level. To reduce the selectivity of examples by the report authors and to indicate the breadth of activities being undertaken by LPCs the full list of responses has been included as part of this appendix at the end, see note one. The other primary reason for adding in all quotes for this question is to continue the process of sharing practice where appropriate.

Figure 5. Summary of LPC views regarding the importance of different roles it can potentially undertake



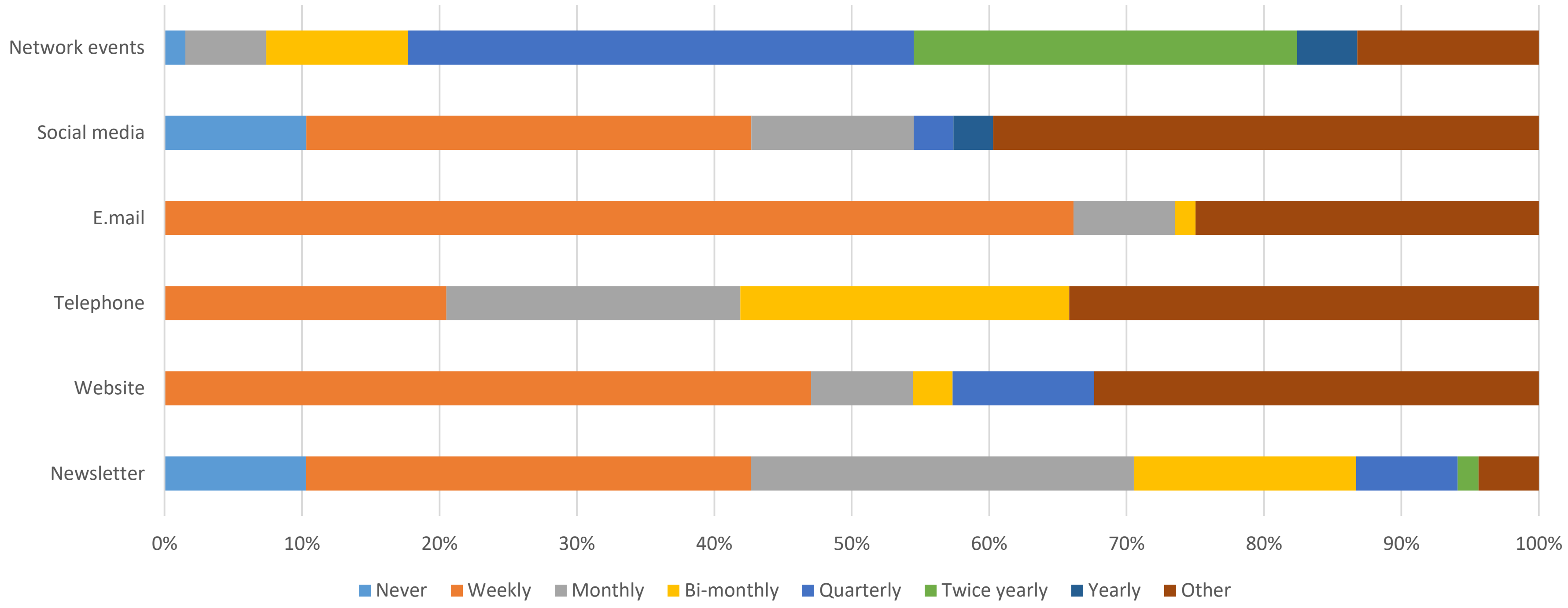
Section 3: Communication

Figure 6 shows how frequently different methods of communicating with LPCs are reported to be used by the different LPCs. Other methods included the use of Whatsapp for “quick fire responses” and e-mail gaggle groups, particularly for PCN leads.

Comments relating to how communication can be further enhanced included:

- Reduce duplication – focussed communication (focus on local): “Contractors get lots of info from a large number of sources. The LPC needs to find its niche and less can often be more.” and “psnc should have a clear weekly newsletter and no other duplication of that information, if it doesn't have a local outcome”
- Use different channels e.g. WhatsApp, Podcasts etc – more digital methods: “Utilise the new PCN Leads as a communications conduit for PCN information/development. Use of Apps should be investigated. Interrogating data/analytics to best match information dissemination with the most effective methods. LPC communications should be focussed on providing information that is not readily available elsewhere, e.g. from PSNC etc.”
- Conference calls and webinars: “Conference call facilities for sharing information and best practice. PSNC provide any centralised systems or tools to send out a newsletter. Webinars from NPA/PSNC is helpful but best practice could also be video recorded and uploaded as could other training.”
- Must encourage two-way communication: “Recognise that communication includes listening to contractors as well as conveying LPC messages.”
- Focus on pharmacy/contractor engagement and how to improve it: “Persuade contractors to open LPC communications and read them thoroughly, contacting the LPC where necessary to aid their understanding” and “We have an effective buddy system and telephone cascade phone around to support contractors.”

Figure 6. Reported frequency of using different methods to communicate with contractors



Section 4: LPC Performance, governance and accountability

Comments relating to the current governance of LPCs included:

- Need a better system than the current self-declaration to ensure consistency across LPCs
- Should be monitored nationally and be standardised (oversight body needed)
- However, LPCs are accountable to local contractors and so most of the time this should reside and be scrutinised at the AGM i.e. a national body can provide an indication as to how good an LPC is, but the enforcement/remedial action needs to be decided locally (possibly by contractors at AGM).
- With more and more LPCs employing officers, it is important the roles are set, agreed and monitored to ensure that people are acting within their remit.
- Minority of LPCs thought that their governance was fine.

There were many suggestions as to what could be included in a 'governance framework' and the wide acceptance that this needs revising. There were some views that the current constitution is too broad and needs bringing together with codes of conduct and other policies. There was wide agreement that this needed to be a national standard to ensure consistency across all LPCs.

Suggestions as to what could be used to benchmark LPCs against each other included:

- Contractor satisfaction/feedback
- Return on investment from levy
- Additional income
- Need some sort of score card
- Representation
- Relationships
- New innovations
- Transparency of costs between LPCs including staff time and costs
- Attendance at meetings/training
- Must be a driver for improvement not drive to the bottom
- With a national standard for roles and responsibilities then benchmarking will become easier.
- Performance to the national contract
- Needs to be in relation to actual size as not every LPC will have the same resource.

53 (73.5%) of LPCs believed that the current system of no external oversight was not appropriate. Many LPCs reported that external oversight was achieved through their contractor members particularly by the publication of their annual report and accounts. However, one LPC stated that this relies on the LPC being open to challenge. Many LPCs responded that there should be some form of external oversight and that this could either be a national body, a regional person or review by a neighbouring LPC.

100% of LPCs believed there should be codes of conduct for LPC members. Almost all responses referenced the Nolan Principles as a basis for a code of conduct. A small number of comments also signified that this code of conduct needs to apply to meetings and behaviour in general.

Section 5: Financing LPCs and PSNC

There were three broad ideas reported in this section:

1. Keep it the same as it is now
2. Fund PSNC and let the money come down to LPCs (one person mentioned the worry about the RPS model here where LPFs have disappeared)
3. Fund PSNC and LPCs separately, so that the contractor knows exactly how much money is going where.

Overall:

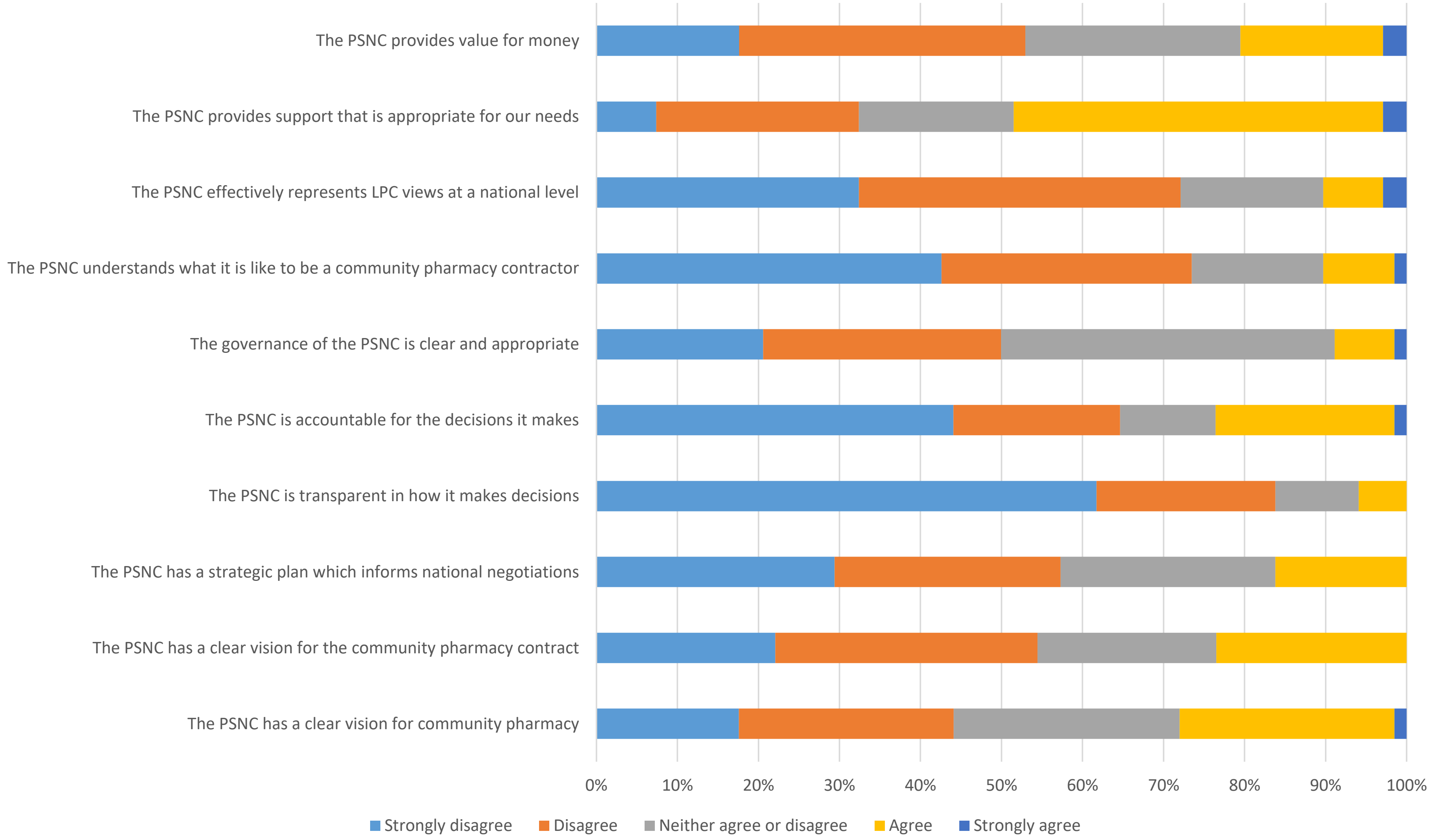
- Transparency is key – contractors need to know what they are paying and why
- General agreement that funding cannot continue to be based on NHS items – although some variation on what should replace it: NHS income, number of contractors
- Some funding should come from central government
- There is currently not enough money for the PSNC to negotiate properly and therefore a general sense that the PSNC needs more but that this could potentially be achieved through efficiencies in the system.

Section 6: PSNC

Figure 7 provides a summary of LPC views on the PSNC. In summary:

- The PSNC has no clear vision for community pharmacy or the community pharmacy contract
- The PSNC has no strategic plan that informs national negotiations
- The governance and accountability of the PSNC is not clear
- The PSNC does not understand what it is like to be a community pharmacy contractor
- The PSNC does not effectively represent LPC views at a national level
- Support provided by the PSNC is appropriate for LPC needs
- The PSNC does not provide value for money.

Figure 7. LPC views regarding PSNC



With regards to vision comments included:

- Needs to articulate vision better, if there is one.
- Not sure what the vision is.
- Poor communication as to vision
- No clear vision for a sustainable sector, no roadmap
- Lack the skills to realise the vision
- No transparency as to the development of a vision
- Feeling that the vision is dictated to PSNC by NHSE&I and DoH
- No clear link to the CPCF
- One response classified the current vision as “uni-professional and transactional rather than relational and multi-disciplinary”
- Reactive

With regards to a strategic plan, comments included:

- “We don’t know what the plan is” – multiple responses
- No consultation with LPCs on a plan
- No demonstrable national strategy
- Plan not shared or clearly understood
- Current plan not an effective tool for driving negotiations
- Need a long-term plan (more than 12-24 months)

With regards to decision making there was almost universal support for the comments below:

- Little transparency – not clear how decisions are made and not able to challenge them
- Secrecy – most appreciate the need for some secrecy but that this has possibly gone too far
- LPCs and contractors should be able to hold PSNC to account and at present there is no clear way to do this
- No input into decision making for the average LPC or contractor.

In relation to the governance of PSNC the majority of responses centred on a lack of information available about whether to judge this as appropriate. Most articulated that Governance structures and procedures were not clear and this needed to change. This included being open and transparent about internal PSNC structures.

Most respondents highlighted that the PSNC did not really understand what it was like to be a contractor – particularly the cash impact of the CPCF on businesses. There was a difference in opinion between the committee and staff (staff have no knowledge as they are too far removed). Those committee members with actual businesses do understand i.e. those on the NT who are removed from the day job perhaps do not. Some comments not just related to an understanding of costs but other things e.g. mental health.

With regard to representing LPC views at a national level, comments included:

- LPCs not asked for their views – no questions or comments asked for by PSNC.
- Hard to communicate upwards
- Some have a good experience with their reps and some comment on a lack of comms with them.
- Sometimes feedback can be taken in a defensive manner (comment seen in multiple sections from different participants)
- They present their views not those of contractors or LPCs
- Represent a small number of (louder) LPCs

For support provided by the PSNC, the majority of comments were positive and included:

- Good website and resources
- Lot of information undertaken at a local level because it takes so long to come out from a national level.
- General feeling is that the support that is there is good however, this is either “too much and too frequent e.g. PQS or too little and too late e.g. data protection”
- Support much better than representation
- Ask for it and you will get it (most of the time – sometimes there can be delay and vagueness to advice)
- Could engage in providing more support

The degree to which PSNC was providing value for money was answered with the following responses:
- “Cost to negotiate big contract is low but outcome is poor” – common theme
- Too little transparency to judge this question – not clear what the money is spent on
- Not fully clear what the PSNC does
- Some comments around being careful about moving money to PSNC – there is a recognised need for this but this needs to be monitored and cannot be at the expense of local funding.
- However, lots of comments about the need for greater resources for PSNC to do its job effectively
- Need to demonstrate a return on investment.

100% of LPCs believed there should be a code of conduct for PSNC members. The answers to this question related very closely to those asking about a code of conduct for LPC members i.e. the Nolan Principles as a basis. However, again, there were also comments about behaviour and meeting etiquette and declaring conflicts of interest.

Descriptions of what the PSNC does well with respect to national representation included:
- Communications – good at communicating important decisions
- View that this has changed in the last 18 months
- Stakeholder involvement
- Poor negotiating committee/team
- Good website
- Quite a few responses that can be summarised as “Don’t know”
- Improved relationships under the new CEO
- PSNC has little public visibility and therefore not sure how to answer this question
- Good at reacting to changes imposed
- Lots of variation in comments – no consistent theme.

Suggestions as to how the PSNC could improve its effectiveness with respect to national representation included:
- Communication with all stakeholders and the public
- Consultation with LPCs
- National specs for local services
- Greater focus on services
- Better negotiating skills/team
- Need a bigger, better quality team
- Sharing best practice / service innovations / vision etc
- Learn lessons from other organisations e.g. BMA
- Clarify role with respect to other pharmacy organisations e.g. NPA, GPhC, CCA, AIM, RPS
- Clearer decision-making process and ability for LPCs to challenge decisions

- Need a single voice for pharmacy
- Great analysis of data and modelling to inform discussions/negotiations
- Co-operation and partnership
- More proactive

Suggestions as to how the relationship between LPCs and the PSNC could be enhanced included:
- Transparency and engagement
- Need PSNC to lead and give direction to LPCs
- “Joint working – one vision, one plan”
- Regular two-way communication
- Clarity of roles
- Some inconsistency as to whether the LPC or PSNC should be the ‘leader’
- Build trust and openness
- Clear reporting/communication lines
- Needs to be a better regional link
- PSNC should not lead for everything
- PSNC and LPCs should share the agenda

Remaining comments about the PSNC concerned:
- Terms of office for PSNC members in the same way that questions were asked about LPC committee members.
- Greater transparency and accountability
- Consulting more with LPCs – two-way communication
- PSNC committee being open to non-pharmacists
- The need to learn from other sectors e.g. GPs

Final comments relating to how the PSNC and LPCs should decide on which recommendations from the review they should implement and the timescale for implementation included:
- Can’t comment until they know what the recommendations are.
- National contractor vote
- Not rushed – clear process for decision, consultation and implementation required
- Need defined timescales
- Collaborative and democratic
- Needs to be open discussion at LPC conference or the meeting on the 5th May (possibly refers to previous comments in the survey about discussion at LPC conferences sometimes being shut down)
- Meeting on 5th May is time for digestion and reflection
- Contractors should decide on recommendations
- For those that mention dates, most appear to centre on implementation between Oct 2020 and the end of 2022.

Note 1: Examples of good practice from LPCs. Some responses were duplicated or triplicated across LPCs that are in the process of merging and these have been reduced to one entry.

We run many training sessions for our contractors. FMD a major initiative, domestic violence, HLP, inhaler technique etc, etc, all very well received.
LPC Buddy system. A cohort of pharmacies was allocated to each LPC member. LPC members then had the responsibility of providing support and relevant communications to their pharmacies. LPC did provide support to contractors in preparing for the new contract. An example being the production of a document signposting pharmacies to all appropriate resources. A high performing provider company: Pharmacy Services North East (PSNE)
Local meetings for delivering services. Targeted contractor support fro local delivery for HLP. Federated working with CPWM.
We employed an enegement officer to help with PQS and we only had one contractor not deliver the PQS. We've rolled out the ENT service and its working because of our engagement. We've laid on PCN evenings and have facilitated fairly electing a lead in each area. We are starting PCN leader training. We produced timelines for PQS. we have implemented Walk in your shoes project for a number of pharmacies and surgeries. We where nominated for a national award for AMR project as we implemented the CRP-testing for URTIs
We have identified key priorities and have contributed to local service development such as Champix via PGD Sleepio trial MAR sheet trial TCAM (value to contractors uncertain). Implementation of PNA Responded to contract applications Individual contractor support
We have focused on the delivery of CPCS to ensure all our contractors (CCA / AIMP / Ind) all understand how the service works. Whilst delivering the National pilot for GP referrals into CPCS we have implemented the service in all pharmacies to great success. Our QPS performance in recent years has far exceeded the National average with focus being placed on supporting those that require help. We have delivered evening workshops attended by CCA / AIMP / Ind pharmacies. Most one to one, in pharmacy support has been directed to the independents with a small amount of double checking of CCA pharmacies. Implementation of the new contract, NHS flu etc has always been supported with "How To" workshops to demystify the new service. The committee set the strategic direction for the next 18 months in their planning and this is implemented by the operational team. This therefore means that the committee play an important governance and scrutiny role. We are also looking at how pharmacy needs to change to be fit for purpose for the new outcomes based contract and we are looking to help contractors transition from a task and dispensing model to an outcomes based framework. We are also providing support to all contractors to generate capacity. This has been emphasised by our work to reduce the number of patients who receive compliance aids. Our pharmacies have been supported to correctly carry out assessments and the LPC works closely with the CCG to issue guidance to pharmacies, GPs, Acue Trusts, carers and other stakeholders in the social care setting.
Refer to Q19 Extensive support through Contract and PCN other changes. PCN packs, Websites, Workplans, Structure, Cooperation between LPCs. See website for examples http://www.warwickshirelpc.co.uk/
engagements roles, reminders to make sure they comply contractually, maximising their income support
Support with PQS, local service implementation. Partnerships with external bodies to provide training. Local advice and guidance to contractors on all matters relating to pharmacy, local services, local NHS stakeholders and regulation. Supporting change in local Health System changes e.g. disbanding of PCT's in England.
pcn lead training day kent self care dealing with emergency crisis situations with cpcs
Digital Interoperability Pairing between pharmacies and surgeries. MAR Chart Service required considerable support by members of the LPC. Support to contractors undertaking the IP training to secure course fees and backfill funding.
Face to face visits to Contractors, PCN packs and support, website, structure. Regional working groups, AHW sharing resource, meetings, locations and guests. Refer to Q19
Refer to Q19 Extensive support through Contract and PCN other changes. PCN packs, Websites, Workplans, Structure, Cooperation between LPCs. See website for examples www.hwlpc.co.uk
We have done a lot of work with PAM project for diabetes and we have won awards for this work, we have also won awards for our domiciliary work locally.
• HLP2- in Suffolk we developed a funded HLP2 framework which builds on the national HLP1 standards but looks to aid effective service delivery and local integration within PCNs • RSPH Centre registration to maximise free training opportunities from external funding provided by HEE/SCC. This allowed us to provide free Health Champion Training to all pharmacies for over 3 years right up to HLP1 becoming core contract. • PCN support- from November to January the LPC, in federation with Norfolk LPC, supported the identification of PCN leads for all our 19 PCN areas, thus allowing all pharmacies to claim the full funding for the PCN domain as soon as the declaration period opened • Pre-reg tutor support- having secured £40,000 from HEE we supported bespoke pre-reg tutor training across Norfolk, Suffolk and Cambridge and Peterborough for 2 years in conjunction with the UEA
Supporting the implementation of pilots/new services - Local NHS E commissioned the NHS seasonal 'flu vaccination service from Norfolk, Suffolk, Cambridgeshire and Peterborough LPC areas in 2016/17. This is now a national advanced service. Local CCG, ooh provider and the LPC agreed to participate with NUMSAS pilot. We worked with them and our pharmacy contractors to be the first area to get the pilot up and running in December 2016. It is now part of the national advanced CP CS service. Arranged face to face training to accredit local Health Champions and pharmacy leadership training. Over 80% of our pharmacies were HLP lev 1 accredited in 12 months from a baseline of 0. Supported contractors, when requested by the NHSE/I Contracts manager or the pharmacy contractor by attending routine contract monitoring visits. Where there are performance issues (real or perceived) by NHS E/I , CCG , PH commissioners, Heathwatch etc, we ensure the community pharmacy perspective is heard.

The LPC CO, who works across 2 LPCs, has developed a pharmacy tracker which is shared with other LPCs in the NW each month. The LPC has a buddy system where LPC members will contract contractors to discuss key issues. LPC committee members / CO make regular visits to contractors to offer support – this is especially important where there are new managers, changes of ownership, new services or where we are aware contractors are struggling. The LPC supports contractors with comms and calls to ensure they meet contractual obligations – this includes CPAF (all contractors completed), DSP Toolkit (all contractors completed), PQS (all, bar two met the requirements) The LPC supports contractors during contract monitoring visits by the LA.
contractor events for changes to contract
Locally commissioned services negotiated and supported in Norfolk include the local direct Funded Emergency Supply Service, and the Norfolk Medicines Support Service. These bring significant additional income and are not commonly provided elsewhere. We have a pilot BP/AF service. Recent federated work e.g. support for the PQS PCN domain has been cited as exemplary. Federated communications, and previous HLP support (externally funded) have also been extremely well received. Targeted and limited support for PQS Gateway attainment has also been cited. Recent securing of system funding to develop and implement a range of PGDs to complement CPCS is seen as an exciting development, and could not have been achieved without effective LPC advocacy.
Healthy Living Pharmacies training Walk in my shoes Weekly Digest PCN Lead training PQS support
Best practice events provide a training and support platform for team members and staff to share their good practice and receive resources and training for campaigns and services. The LPC provide a strong training function internally currently as an RSPH training centre, MHFA training centre also. Support of unexpected closure within 24 hours when a legal issue prevented the owners from acting, 3 members of the LPC employed team contacted every patient, GP, Nursing home, substance misuse provider and many other to ensure there was safe closure. Staff were supported to gain alternative employment within the area keeping the expertise local. NHS England liaison to ensure controlled drugs were removed and the premises was made safe during the closure and becoming an unlicensed premises. CPCS- LPC were strongly involved in the roll out of the pilots of CPRS/DMIRs, then transition into CPCS, we liaised regionally and provided the hands on support to both call handlers as well as contacting every pharmacy in the region ahead of launch to ensure maximum sign up and effective/rapid implementation Chemist and druggist award for excellence in training and development has been achieved. All contractors are visited once per quarter by the employed team to ensure they have a full understanding of the PQS system, service maximisation and funding as well as any other query which may come our way. Feedback from visits is excellent with all contractors engaged and aware of the support that is available. Locally we meet with all commissioners and stakeholders at least quarterly with some more frequently to ensure full transparency of all working practices and opportunities in pharmacy. Local public health team have recently paid the LPC to provide hands on support to contractors around stop smoking and we have also been commissioned by our sexual health provider to delivery not only all pharmacy staff training but also pharmacy visits to support maximum uptake of services. The Chief Officer has a bi monthly meeting with the senior director within the CCG who is coordinating the local PCN groups with support for all pcn leads to ensure full dissemination of information and development work is consistent and fair across the area.
Service administration – LPC funded to act as agent on behalf of commissioner, provides PharmOutcomes platform (easy way to record service delivery and make claims), and ensures contractors paid monthly without completing any additional claims paperwork. Provides non-levy income. Project support – LPC funded to develop, implement and support ongoing service delivery. Enables LPC to support all contractors to deliver what commissioners want. If delivery of high quality to volume wanted by commissioner = a successful service and more likely not to be decommissioned. Delivering project support gives CPWY a positive reputation. Provides non-levy income. LPC without a provider company that attracts non-levy funding to undertake actions for others (eg project support) that • Ultimately meet the aims of the LPC by providing enhanced support to contractors • Helps secure services, inc ongoing commissioning, as CPWY help contractors to deliver the outcomes that the commissioners want • Non-levy funding (as not part of separate provider company) can be used flexibly within the LPC to provide enhanced support to contractors eg PCN funding, monthly CPWY Connect events • Noted that PSNC Gordon Hockey stated CPWY approach with this (rather than having a provider company) was 5 star. LPC reactive and flexible to changes and support needed by contractors. E.g. Arranging CPCSs and FMD events at short notice, review of newsletter following committee feedback CPWY employed team ensure that things get done within timescales and progress made. Having employees to carry out the operational elements of the LPC is efficient as it is the day job for the team / there is the relevant skills across the team and also in terms of value for contractors (costs of employed team vs costs of committee honorarium). Employed team also removes any complexity of tax / NI of committee members being directed to carry out a role (suggesting employment). CPWY encourages challenge and conversation – and following governance in an open and transparent way.
Peer discussion meetings to facilitate revalidation. Annual contract "training carousel" for mandatory, statutory and Quality Scheme training. Support for performance concerns, CPAF visits, breach notices and appeals. LPC chief officer has undertaken case manager training with NHS resolution. Joint working with 2 AHSNs to implement/support TCAM hospital discharge pilots. Complaints response-drafting service.
Close links with PH & CCG. Initiatives from local relationship with Keele Uni and Public Health e.g Joint Care in Pharmacy Project, and with WMAHSN on Atrial -Fibrillation screening project, collaboration with IT leads at CCG on SCRai for pharmacy, extended ENT project developed with Staffs LPCs and NHSE.
The LPC has provided training sessions on inhaler technique; support and training for our Pharmacy4mums2B initiative across three boroughs (two Middlesex LPCs); clinical update sessions utilising a GP trainer in one borough; a smartcard updating session; a workshop on Summary Care Records; joint meetings with the Local Pharmacy Forum (previously the RPS 'branch'); a joint Sunday session with NHS England on DMIRS (now CPCS) which included a session on FMD
PCN leads appointment and training PQS training and support Newsletter Deadlines newsletter shared with LPC CO HLP Northamptonshire Facebook page with daily feeds

1. Working with Swindon CCG on the set up of their Prescription Ordering Call Centre a. While other LPCs were opposing the set up of such organisations, in Swindon and Wiltshire we were an integral part of the steering group overseeing the set up b. Our positive input supported good consistent messaging to patients about the timescales within which prescriptions would be ready for collection. Additionally messaging on prescriptions that had been processed through POD to help pharmacies manage workload c. We set up PharmOutcomes templates which allowed pharmacies to order prescriptions for patients on MDS. This helped provide a paper trail of requests including visibility on when prescriptions were ordered. POD staff could manage the preparation of these prescriptions by appropriate staff at times of lower call volume. Contractors benefited from a standardised approach across all surgeries in the CCG d. Good relationships helped sort out any problems between pharmacies and prescription ordering 2. Piloting and support for a PharmOutcomes referral service between the secondary care anticoagulant clinic and Swindon Community Pharmacies a. Positive feedback from pharmacies about patient reaction to NMS invitations related to anticoagulants started in secondary care b. Positive professional relationships built c. Evidence of patient benefit – patients who would otherwise have dis-engaged from treatment d. Initial resources included a well received 1-page guide to anti-coagulant issues for NMS 3. Piloting and support for one of the earliest TCAM projects. a. One to one follow up with pharmacies to understand the benefits of receiving discharge notifications for patients receiving MDS 4. Stop Smoking Service support a. Deep dive by support officer to understand why quit rates appeared low b. Better understanding of difficulties pharmacy advisors had in completing templates c. Training for staff where appropriate and negotiation with commissioner for changes to recording requirements where appropriate 5. CPCS Implementation Support a. Through excellent relationships with OOH provider, follow up with pharmacies has been possible where patients have returned to NHS111 b. This has allowed contractors to follow up with individuals where CPCS had not been followed correctly c. LPC has been able to provide feedback to OOH team where their expectations have been unreasonable and support contractors where actions have been appropriate but not seen that way by patient. 6. Relationship Support a. Especially around MDS issues, educating other health professionals around reasonable expectations
In London we launched the flu service, PURM, NUMSAS. We support contractors with many issues such as regulatory matters, failing pharmacies in the area. Prompting NHS England (London) to make payments that were taking too long to come through. Locally commissioned services that have been negotiated here such as domiciliary visiting and MURs, palliative care, respiratory programme in Richmond, quit smoking before it became a national public health service, alcohol service, healthchecks, collaborative marketing of community pharmacy services, CCA and independents together via off-site testing, contracts for local public health services/ contract extensions and improved payments, minor ailments. In South West London we are in the process of agreeing a common service contract and specification for the area that national and local pharmacy bodies can deliver. Under that will sit local borough variations that the local LPCs will be needed for agreement and support for local implementation. We work with the AHSN on TCAM and that is to lead into the coming national service on referral to community pharmacies from hospitals.
We have held training workshops on a diverse range of topics such as inhaler technique, the Falsified Medicines Directive IT issues
PCN event, SY joint training events last year, conflict resolution between practice and pharmacy, NHSE and pharmacy. Care Navigation
PCN event, South Yorkshire joint training events with neighbouring LPCs last year, conflict resolution between practice and pharmacy, NHSE and pharmacy. Care Navigation Performance issues around breaches Better relationships with CCG
Support contractors with QPS – 100% compliance (recognised by NHSE) Work with NHS Digital to install Emis-read into pharmacies Smooth launch of CPCS Successful dispute resolution and mediation Developed a strong PCN leads support network with L&D Developed L&D zones across our rural LPC Alcohol brief intervention service – new revenue stream Structured medication review in AF/stroke -new revenue stream Pharmacy/GP integrated flu vaccination project to increase uptake levels Working with multiple pharmacy leads
Interactive flu map; training for HLP (Health Champion and Leadership); Training and contractor events; Visits to community pharmacies by LPC Officers to raise awareness/share good ideas/identify issues and offer solutions; Regular communications including Newsletters and social media; Additional funding to support PCN leads; Good work with the LPN to pilot several LES; Work with DeMontfort University on QI in community pharmacies; monthly columns promoting community pharmacy in local papers and a monthly blog.
Good results with Quality payments because of the resources the LPC provided, the site visits (Dementia Friend training), lots of one to one support / conversation by phone/email. High return rates for CPAF declarations because of support. Attending cross organisational meetings to promote pharmacy and offer services. Training sessions - EHC, flu, HIV, Hep C HLP- note in particular that our LPC area achieves excellent (best in northern region) flu vaccination rates per pharmacy because of extensive support, training, mentoring offered over the last few years. This has brought considerable income to our contractors. Staff on the ground at local level to support - CPCS, PQS, NUMSAS, TCAM, eRD, Pharmoutcomes, training, HLP, queries, development, networking, PCNs (training event and external support) , All services, F2F visits, eRD Close working with CCGs to jointly deliver services with support, development, training and knowledge/experience
we have initiated an AF project in conjunction with Harefield hospital was this made available for all contractors to take part in.

Directed contractor visits – we employ a full time Operations and Contractor Lead, whose role is to go out and support contractors, and be the "on the ground link" into CPL. On an average week 18 contractors will be visited using a structured visit plan. Working around our 8 CCGs these visits can be ad hoc, targeted or requested. e.g. Contractor support from the launch of the Community Pharmacist Consultation Service (CPCS) in October 2019 up to January 2020. Targeted contractor support has been given via the CPL staff team using the performance figures released by NHSE&I to support contractors in delivery of CPCS. Our contractors have received a total of 4,193 urgent supply queries, with the minor illness element having a total 2,532 minor illness queries. When comparing CPLs 'completed' figures to national figures, we are outperforming the national average by 6% for Urgent Supply and by 5% for Minor Illness, which we would suggest is evidence of this support based intervention of a national service. Our approach to appointing Community Pharmacy PCN leads for the recent domain of the Pharmacy Quality Scheme (PQS) was both effective and appreciated by the contractor network as they saw a tangible benefit and recognised this would not have been achieved without the LPC co-ordination. The work we delivered has enabled contractors the potential to access a minimum of £295,200 of funding from this one domain of the PQS. CPL has developed the Refer to Pharmacy Scheme in conjunction with East Lancashire Hospital Trust, to improve the patient discharge process and increase patient safety amongst other aspects. Operating to a very high standard and is evidence based; this work has been mirrored by others within the Transfer of Care About Medicine initiative rolled out across England by Academic Health and Science Network (AHSN). Contractor Support Events – over the past 12 months we have held over 20 contractor events ranging from national topics, professional regulatory topics, local events all supporting the delivery of national and locally commissioned services from our three Health and Wellbeing Boards, through to targeted workshops to help those struggling with national services. We provided an enhanced offer for Healthy Living Pharmacy accreditation to Level 2 funded by NHSE&I Our trackers, newsletters and website are peer reviewed and considered to be amongst the best across the national LPC network. We provide fully funded access to Virtual Outcomes as a training resource for all our contractors Close working with Choose Health our provider arm company who have successfully bid for three commissioned services working with NSE&I, Lancashire County Council and the British Heart Foundation respectively. These opportunities have been open to all contractors
PCN Leads in place and packs produced for Clinical Directors, Respiratory events, Cross sector training. BBV, HepC, AF Screening- cross sector including CCA. Reinvested smaller committee into resources to achieve outcomes and employ a service development lead, tangible example of prove results having "boots on the ground" to support contractors for BBV.
Support and co-ordination of the Primary Care Network domain of the pharmacy quality scheme which will bring just under £400k into the pharmacy network Collaborative clinical update and Primary Care Networking Primary Care Network leadership development Survive drive and thrive workshops Achieving alignment of Emergency Hormonal Contraception service across three local authority commissioners Achieving commissioning of pharmacy first services as mainstream service after running a pilot with NHSE funding LPC golden pages newsletter with local news highly valued by all pharmacy teams when surveyed Putting together the local pharmacy response to a local practice closure in Plymstock and an anti-viral service at Christmas; both turned around very quickly because of our local leadership. A collaborative approach to providing flu vaccinations in a locality in Devon which benefited from local leadership. Support for the CPCS and GP CPCS with pharmacy visits even though the former is a national service - Pharmacy staff on the ground still need local input. AGM and Pharmacy Awards – sharing great local best practice Supporting failing dispensing doctors practice with community pharmacy support Inhaler Use Review pilot extended to rest of County and nationally Providing contractors with insight into contract compliance Identifying opportunities for community pharmacy offer for Improved Access and getting local services commissioned Pharmacy system integration with SystmOne
We have provided training for new services e.g. flu vaccination training for a pilot scheme before the national scheme; we then ran regular flu events over several years with signposting to training resources which helped to embed the national service in Thames Valley. We worked with CPPE and HEE to ensure that HLP became the norm in Thames Valley. When the first QPS scheme was launched we ran a series of engagement events for contractors which were very well received. The committee undertake visits to contractors before LPC meetings to gain feedback, raise awareness and show support. We introduced a weekly e-mail digest to reduce the volume of e-mails going to contractors. We set up a WhatsApp group and use that to share the digest, newsletter and good practice. We have also worked very closely with CCGs and Public Health teams to develop the understanding and value of pharmacy. Our Chief Officer has supported contractors to prepare for CPAF inspections, supported them through performance management issues with NHS England and supported one owner through a suspension and closure. Our most recent event on PQS and PCNs was very well attended and received with some exceptionally positive feedback from contractors who value these interventions from the LPC.
Many examples. To name a few: EMOP & TCAM, PCN mappings and Pharmacy PCN Lead identification, AF/BP monitoring, Healthchecks, HIV service plus support to deliver locally commissioned services
Additional employed roles: • Professional Development Pharmacist [Since 2000} - To assist the LPC in developing effective, relevant community pharmacy services for delivery within community pharmacies in line with the LPC Work Plan and LPC Strategic Plan – Job description available if required. This role has secured and developed numerous local pharmaceutical services across 4 CCGs / local authorities. Currently we have commissioned 15 local pharmaceutical services. • Health Integration & Public Health Lead – Field Role [since 2017] which develops relationships and maintain contact, through a variety of mechanisms, with community pharmacy contractors and their teams across the Humber area – Job description available if required. • Pharmacy Services Lead – Field Role [since 2017] which develops relationships and maintain contact, through a variety of mechanisms, with community pharmacy contractors and their teams across the Humber area – Job description available if required.
Pharmacy First for extended care service see: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4125-y
• CPAF visits • CPPQ support • MDS support • Locality events • MP visits • E News
• Newspaper article for stock shortages to support public understanding and aiding contractors to support their patients appropriately through collaboration with other contractors and GPs. • Dashboard of activity • PCN – Election, lead support, Office 365, leadership development • Local services guides & tools – using novel technologies • Personal calls re: PQS, training events, press release to alert public to pharmacy issues, Pharmoutcomes support across the patch, locum/pharmacist handbook, monthly published timelines, up to date website withal relevant links and resources. • CPCF support locally • Change management and leadership coming up for PCN leads (note: this is not from levy funding)

The LPC ran a successful series of local Engagement Events in November to support contractors with the new contract and development of PCNs – as a result we have the 9 Community Pharmacy PCN Lead places filled and all contractors able to claim the PCN bundle of PQS if they wish to do so. Our LPC staff track progress with PQS where data is available and offer support to contractors. The LPC Chief Officer, who works across 2 LPCs, has developed a monthly pharmacy tracker, to remind contractors of key activities and deadlines, which is shared with other LPCs in the NW each month. Local training briefings have been developed to support pilot services e.g. Blood pressure services and localised CPCS support due to local pilot of on-line CPCS. Development of innovative pilots in collaboration with the LPN/AHSN – the LPCs leads on the Blood pressure projects and represent community pharmacy on the STP BP board. We have pilots for AF detection and medicines optimisation, GP DMIRs, CRP, E-consult. LPCs across C&M have been integral to the implementation of TCAM in the region which has won national innovation awards with all hospitals live. We encourage commissioners to use common Patient Group Directives (PGD) across the Cheshire and Merseyside footprint e.g. there is a single EHC PGD used by local authorities in the region which provides consistency to pharmacists and locums employed by contractors. The LPC Engagement Officer make regular visits to contractors to offer support – this is especially important where there are new managers, changes of ownership, new services or where we are aware contractors are struggling. Contractors who up until recently didn't have consultation rooms are now providing national services as a result. Our engagement officer has provided comprehensive support to contractors for the Pharmacy Quality scheme and to ensure that they meet the new mandatory requirements for HLP as part of the CPCF. In addition, the LPCs supports contractors to confirm participation with public health campaigns which it appears will become a standard requirement nationally. The LPC staff supports contractors with comms and calls to ensure they meet contractual obligations – this includes CPAF, DSP Toolkit, PQS.
nomination issues, pastoral care, support with conflict issues
- Naloxone supply embedded into Substance Misuse contracts. - Hep C screening. - Communication with contractors. - Defending breaches and recovery of funds from NHSE. - Rx Direction - advice to all contractors , without support from national bodies. - Media campaigns - promotion of Flu Vaccination Service - Recruitment of Service Development Officers , which has led to great co-ordination of PCNs across 38 PCNs, - Re-appointment of Corporate Governance Officer.
HLP Support (via Community Pharmacy Development Officer) to ensure that most of Dudley pharmacies were Level 1 accredited for QPS in Feb 2019 and re-accreditation where appropriate. Ongoing support to ensure accreditation by April 2020 for PQS scheme. LPC has facilitated a number of support events for Quality Scheme to assist contractors through collating information and making claims successfully LPC has previously arranged flu training for pharmacists to undertake private/NHS training, and supported through marketing with LPC's provider company (Central Health Solutions) Liaising with provider company Solutions4Health for unpaid monies to contractors– resulting in successful resolution
Several evening events were held in October to promote the new contract and set up Primary Care Networks. A lot of work went into the events to ensure pharmacies were aligned to the correct network, and packs were produced for each pharmacy detailing their PCN, and key take away information. Subsequent to this, we have ensured all pharmacies had the opportunity to claim the PCN domain of the pharmacy quality scheme through encouragement of those that did not attend an event, or who did not vote in the PCN Lead elections to engage with their local pharmacy lead. We also spent a lot of time producing information and supporting pharmacies to achieve all pharmacy quality service domains. We track where pharmacies are up to, and provide assistance if and when necessary. We also provide excellent support to contractors in Liverpool through our Engagement Officer. He tracks service provision and contacts pharmacies that appear to be struggling to provide a service. We track progress post-contact, and we know that his role brings more money into local pharmacies than the role costs the LPC.
Dorset LPC is exceptionally supportive of all of its contractors. We encourage our contractors to sign up to local services/resources that we have negotiated for them. In the last few years we have secured funding for or access to the following: Dementia Friendly Pharmacies Framework, Diabetes Focus Pharmacy Framework, HLP training, Walk in My Shoes project, eRD pilot with support for pharmacies, eRD stamps, PCN Lead development day, VirtualOutcomes training platform (75% of contractors are actively using it), CPCS GP referral pilot, TCAM, support for recruitment of workforce, joint pre-registration pharmacist and technician placements with GP practices/secondary care.
• Membership of the Pharmacy Board and the Primary Care Board with voting rights which feeds into the Greater Manchester Health and Social Care Partnership executive. This is part of the Greater Manchester Health & Social Care governance structure. • Pharmacy has a seat at the table at various forums and boards within Greater Manchester Health & Social Care Partnership. • CPCS / TCAM implementation support for contractors. • The work currently be done around the PQS claim and ensuring that the LPC has 100% PCN coverage with appointed leads for all 58 PCNs. • 9 x PCN engagement events delivered across GM. • Agreement between the NHS and the LPC on collaborative working practices with Community Pharmacy for PCN engagement to support integrated working. • Development of the training academy. GMLPC Academy training has increased service uptake of NMS and MURs. • New CPCF contract support and engagement with contractors to deliver the requirements. • Inhaler technique service GM wide in partnership with the NHS. • Formation of the Pharmacy provider company – and the driver of the model articles adopted nationally • Merger of 6 of the 7 LPCs in Greater Manchester • Decision to undertake an operational review in order to provide a more effective service for contractors in GM • QPS support (2018-19) • PQS support (2019-20)
In times of crisis, the committee rallies. For example, one independent contractor passed away over a Christmas period. The committee was contacted by the family on 27th December and a number of committee members and the Chief Officer provided support to the family. Support commenced on the same day we received the call. The Chief Officer visits every contractor twice a year. This is important to ensure we are supporting contractors and ensure we are meeting their needs. We undertake an Annual Contractor Survey. This is important to ensure we are supporting contractors and ensure we are meeting their needs. One participant felt that a gap that the LPC could offer was 'tips and pointers; on income. A discussion within the group felt that this could be offered, for independent contractors, by NPA.
Quality Payment spreadsheet which was sent out in small messages for contractors to complete their assurance to gain maximum quality points. To be part of Pharmacy London and ensure the pan London Vaccination service, PURM, NUMSAS, DMIRS and CPCS were successfully planned, implemented, mobilised and delivered. This meant that local contractors were able to access new sources of funding.
Senior pharmacists group (Community/Hospital/CCG) representing pharmacy to the STP. Contractor Development & Support Manager - personal visits. Monitoring of service delivery and targeted support. RAG rating of services to commissioner and contractor. Working with commissioners to deliver implementation, therefore obtaining quick results.

Quality Payment spreadsheet which was sent out in small messages for contractors to complete their assurance to gain maximum quality points. To be part of Pharmacy London and ensure the pan London Vaccination service, PURM, NUMSAS, DMIRS and CPCS were successfully planned, implemented, mobilised and delivered. This meant that local contractors were able to access new sources of funding. LSL has in the past engaged in "Ask Your Pharmacist" week to promote LSL community pharmacy locally.
Producing consolidated QP workbooks for contractors and and Hosting QP/PQS workshops to support contractors to submit their claim Hosting/facilitating clinical, regulatory, health landscape update meetings Chasing contractors to meet their QP/PQS gateway criteria Chasing contractors to complete the various mandatory NHSE submissions, IG, CPAF etc To be part of Pharmacy London and ensure the pan London Vaccination service, PURM, NUMSAS, DMIRS and CPCS were successfully planned, implemented, mobilised and delivered. This meant that local contractors were able to access new sources of funding. Through which we have had the London Community Pharmacy Strategy agreed with NHSE London (to be published n March 2020)
Strategic engagement across two integrated systems, six local authorities (inc. HWB boards, PH groups and Healthwatch), six CCGs, 44 PCNs, six GP federations and three large acute trusts. NEL community pharmacy, via LPC representation, is fully embedded into these local structures, informing structural development, system intentions, transformation Development of an innovative model of care - High Street Clinic Workforce development (see above), including supporting contractors in terms of IP courses, advanced diploma, Mary Seacole, etc., via Pharmacy Integration Fund Mobilisation (engagement tool kit, regular briefings of Local Community Pharmacy Network teams across NEL Alignment of DES specifications with the role of community pharmacy - work to support local understanding and joint working to inform role of CP in local PCN agreements Development of a community pharmacy provider organisation for NEL to support contractors the commissioning, contracting and delivery of community pharmacy services. Development of Community Pharmacy Offer in collaboration with Pharmacy London and facilitated by NHSE, outlining our offer to the system and our ability to deliver based on development of key enablers, ie. interoperability, workforce and premises Development of NEL Workforce Plan to support engagement and business case development.
Most recently, we delivered four events for contractors to share information about PCNs, highlight the role of the PCN lead and allow contractors to agree or elect their PCN lead pharmacist. This has been supported by a robust PCN hub on our website, enabling contractors to see clearly how they fit into their PCN. In recent years we implemented two local services, following successful funding bids for non-recurrent funding (NRF). With these, the LPC actively managed delivery of a successful minor ailments scheme, and an emergency supply scheme on behalf of the local NHS team. These schemes ran for longer that the initial bid anticipated and were withdrawn due to local and national changes. These were managed efficiently through the PharmOutcomes platform, which was also funded by the LPC as a result of another NRF bid. Funding of the PharmaOutcomes platform has enabled us to utilise this for service development and implementation, providing consistency and stability for contractors.
We commissioned radio advertising to promote the locally commissioned flu vaccination service, prior to this being commissioned nationally. We have also commissioned a video to explain the prescription ordering and dispensing process and timescales involved to explain this to patients and encourage them to order prescriptions a week before they will run out of medication. The video can be used in pharmacies, will be on the LPC website and our local Healthwatch websites and will be provided to GP practices for their waiting room video screens. The committee was one of the initial members of a novel provider company, PSNE Ltd, with two neighbouring LPCs. As a not for profit company, any profits generated are paid to the LPCs which generates significant income to the LPC over and above the levy. This money is invested to support contractors. We have also invested in additional short term contracts to employ addition staff to support specific work such as PCN support lead and HLP support, plus additional hours from a pharmacy team member to support engagement with a blood pressure testing service.

• At each LPC meeting, as we go through and cover the different items on the agenda, consideration is given to note down any pieces of information/to note or to action/alerts that are felt to be useful for contractors to know about, are noted by a member who acts as a scribe (rotational basis at each meeting). Within 24 hours, the scribe beefs up these "Dissemination Points" with appropriate facts for relevance, addition of a link etc and these are circulated to all contractors by individual "Cell Leads" circulating to their "cell groups" by email. Contractors are encouraged to keep these dissemination points in a file on their desk top after auctioning them for future reference. The LPC considers this an extremely good way to get important current information that needs auctioning to contractors quickly. Also we have found over time that many pharmacy teams have realised the benefits of this resource and have made reading these dissemination points as a priority action • The LPC operates a Cell Structure – each member is a Cell Lead and has between 10 & 15 Contractors in their Cell who they provide direct hands on support to on a day to day basis. Between themselves individuals from the pharmacy team often share their personal contact details with their cell lead for quick access. Besides the dissemination point circulation, it is the cell leads who will contact individuals in a pharmacy in their cell for other issues eg delivery on a particular service, non-completion of CPAF with a deadline approaching, encouraging them to fill the contractor survey for this Review etc. Some extremely good relationships have been built up over the years between contractors and their cell leads with often a cry for basic help if failing to understand or grasp something new that needs to be done and they come across an issue eg registration process for a new service which is not working properly – as they will get quick hands on advice to get it sorted fast • When a contractor shows fantastic engagement of their team with the roll out of a new initiative, and there are others who are finding things difficult and not getting started, the LPC often asks the contractor for permission to pass on their contact details to share their good practice in sorting these issues. Many pharmacy teams are extremely happy t share and support others over the telephone; however we have had examples also of invitations to others to come and observe eg a session of vaccinations, being extended. • Our process for aligning community pharmacies in KCW area against the nine PCNs (Primary Care Networks) and then alongside this, the nomination and appointment process for the PCN Pharmacy Leads was commented on by a couple of people who oversaw this process in multiple areas as they had branches across London and England as being fantastic and one that should have been followed by other LPCs too – because it was apparently the best they came across in their dealings with branches elsewhere. The process, in our opinion was just simple and sensible. • Working with Pharmacy London (Confederation of London LPCs), sharing of good practice with other LPCs, sounding out the others on matters of concern and alerting mechanism – early warning system – is extremely helpful for LPCs here in London • It was our local relationships that enabled us to get pilots commissioned which were made to work well with intensive LPC support such that they were eventually rolled out across London and then nationally (e.g vaccination service); the Hepatitis C Testing service pilot, again with LPC support was extremely successful and gained Ministerial attention and is now to be a Nationally commissioned service • The LPC has gone out on a limb against opposition from peers to support a pilot of TCAM (Transfer of Care around Medicines) which is basically an electronic referral of a patient being discharged from an acute trust, accompanied by an electronic copy of discharge summary – of patients that the hospital thinks might benefit from a community pharmacy intervention once back home; the pharmacist accepts the referral and follows up to ensure that upon receipt of first repeat prescription from GP, a medicines reconciliation is dome at the very least and also follows up on any other issues they identify from the discharge summary – e.g. support necessary re a newly prescribed medicine, a need to provide advice to stop smoking etc etc. There was no payment available as the AHSN had no funding for this; however the LPC felt this process formalised what pharmacists in the community already did for their patients but with the discharge summary in front of them ensuring patient risks were minimised, safety enhanced and communications between GP, CPhcy and Hospital enhanced as electronic messaging for comms and feedback was possible. The long & short of it is that we have generated plenty of evidence on the benefits of this. Now there is possibly a national service based on this to start in a few months and our contractors have already got the processes and contacts in place in readiness…
To be part of Pharmacy London and ensure the pan London Vaccination service, PURM, NUMSAS, DMIRS and CPCS were successfully planned, implemented, mobilised and delivered. This meant that local contractors were able to access new sources of funding. Through the good work of C&H LPC the following are examples of value added for contractors The Pharmacy First Minor ailments service Healthy Start Vitamins Distribution TCAMs service (discharge from hospital) Connectivity to patient records eLPR Sexual Health Services Weight management Medicine optimisation Nuclear contingency preparedness programme Pandemic preparation IT upgrades for Pharmacies Pharmacy premises upgrades using European funding Setting up of a Provider Service company which supports End of Life Care service and the Neighbourhood Leads programme. City & Hackney has been and is a shining example of effective local working .
Funding of Pharmacy BEST by CCG. Pharmacy BEST are bimonthly educational events ran by the LPC on behalf of the CCG. They are intended to optimise the delivery of local (and national) services for the benefit of the patients and the health community at large. The sessions are filmed an added to the BEST website. The BEST website is accessible to anyone working within the healthcare community in Barnsley and contains information on local pathways of care. APC Reporting: The Area Prescribing Committee has an interface issues reporting form that allows anyone working in the area to report incidents. The NHS recognises that transfer of care between different professionals can present risks, APC reporting helps to identify local patterns and serious incidents and reduce those risks. APC reports are reviewed monthly and summarised quarterly. APC reports have led to task and finish groups to improve practice.
Support for achievement of PQS we have given 1 to 1 support to enable achievement Support to PCN Leads, we have supported and encouraged people to come forward, supported their development and are building resource in terms of development and action learning to build sustainable support for them. CPAF Support through 1 to one support we achieved a 100 percent return. This took a lot of effort from the LPC. PCN rollout we have mapped and developed PCN pharmacy links as there was no support from the NHS to do this, our contractors could not even get Clinical director details which the LPC had to put in a lot of work to get as PCN's and CCG's where unwilling to share this information which would have halted progress and not allowed us to achieve the PQS domain linked to this.

• Media relations - guidance on what to say to the media in certain situations, helping empower contractors and providing a press office function to independents. Eg o Lines-to-take are produced and distributed to chairs and committee members, as required to help with local media relations and locally contentious issues Media attention on XXX remains high and most enquiries received by us lately have not been about matters we can comment on. If you receive any enquiries from the media (on any subject) you, of course, have authority to comment, but be sure to consult your organisational policy first! However, you might prefer to refer them on to us, or contact us to help you decide on a course of action and/or agree a statement. Email lpc@communitypharmacyss.co.uk • briefing notes for all contractors to help them in topical situations locally • Strong consistent application of (refreshed) clear visual identity across all communications channels, mostly used in conjunction with the following 'clarifying text': on behalf of East Sussex, West Sussex and Surrey Local Pharmaceutical Committees helps contractors and stakeholders understand the function and reach of our LPCs • Website A-Z to help contractors manage their contracts and access information quickly • Reducing the number of emails sent to contractors from <stakeholders>. By rounding-up everything up into a News from …. Section in our fortnightly news letter • Essential guide to local services • Local contractual and service deadline tracker (now adopted by many other LPCs) – could be scaled or provided centrally, -- good example of where the network of LPCs could be better co-ordinated to avoid duplication
New contract training events, PCN leads engagement events, PQS/Quality points support