Independent Review of Community Pharmacy Contractor Representation and Support:

"Providing best value for contractors"

(Report Overview)

Professor David Wright
Dr Michael Twigg
Dr Hannah Family
Dr Linda Birt

Foreword

On behalf of the independent review team, I am delighted to be able to finally present our findings and recommendations to you. The journey has been incredibly honest and educational, for which we are very grateful. We have to thank everyone who has contributed to the process through interviews, focus groups, allowing our attendance at meetings or through completing surveys. The very strong messages and signals we received throughout the process, along with many excellent ideas for change and innovation, made it a lot easier for us to derive our recommendations.

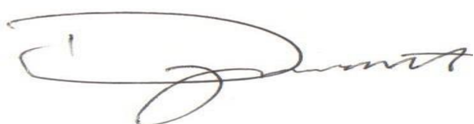
We also have to particularly thank the Pharmacy Review Steering Committee who have provided unwavering support and guidance to the team throughout the process. Their contribution has been central to ensuring that the project was delivered on time and that the report is presented to you in its current format. It was decided that our original report, whilst demonstrating the thought that had gone into the process, was too long and hence it has been divided into two parts. The first provides the main messages and explanation, which we believe everyone should read, and the second the detail and evidence underpinning all of this.

Whilst recognising that what we are proposing is far more radical than anyone envisaged at the outset, we believe that it is fully supported by the evidence. The COVID-19 pandemic may have delayed the report's publication but it demonstrated the value provided to contractors by much closer working between LPCs and PSNC. It has also shown how trust and relationships can be better fostered through better communication and transparency.

With 'providing value for money for contractors' driving this review, we honestly feel that there is the need for the system-wide changes we propose. Changes which allow the contractor's voice to be better heard both locally and nationally, the contractor's money to be used to best represent them and where outcomes from both national and local negotiations ultimately ensure appropriate and fair remuneration. We must not forget that patients are at the centre of this and without appropriate remuneration community pharmacy cannot continue to provide the excellent patient care that it currently does or integrate better into primary and secondary care clinical pathways.

We look forward to discussing this with you at the different planned dissemination events.

Yours faithfully



David Wright

Table of Contents

1. Executive Summary 4
2. Recommendations 6
3. Explanation for recommendations 8
4. Recommendations, evidence, rationale and impact 20
5. Current and possible proposed structure 32

1. Executive Summary

Background

Local Pharmaceutical Committees (LPCs) were set up, with the formation of the National Health Service (NHS), to represent the community pharmacist voice locally and within this to review requests for opening new community pharmacies. More recently, LPCs have additionally assumed responsibility for negotiating and setting-up local services and supporting pharmaceutical needs assessments (PNAs). With a broad constitution, most LPCs have further widened their activities in order to provide additional contractor support.

The Pharmaceutical Services Negotiating Committee (PSNC) is responsible for promoting and developing national services for community pharmacy and negotiating the national community pharmacy contract (the Community Pharmacy Contractual Framework) with the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSE&I). The value of which is circa £2.6bn per year. LPCs and PSNC are funded through an automatic levy taken by the NHS Business Services Authority (NHSBSA) at source from contractors. From this £11.3M per year, the levy is divided approximately 70/30 between LPCs and PSNC respectively, with the PSNC funding channelled through the LPCs.

Recent national contract negotiations have resulted in significant real term income reductions in community pharmacy funding, bringing all elements of community pharmacy expenditure into sharp focus, including the LPC and PSNC levy. The aim of this independent review was therefore to review contractor representation and support, and make recommendations to ensure that contractors receive value for their money.

Method

A Pharmacy Review Steering Committee was set up to support the process. National survey tools were designed following regional focus groups with LPC representatives and contractors and interviews with a number of LPC Chairs and Chief Officers(CO). The surveys were made available in February 2020. In parallel a review of LPC websites was undertaken to determine the level of standardisation of practice, financial transparency and governance. All senior PSNC employees and PSNC committee members were offered an interview using a similar structure to that used within the national surveys. Members of the General Practitioner Committee within the British Medical Association, Community Pharmacy Wales and Community Pharmacy Scotland were interviewed to understand their models of delivery. The information provided from all sources was collated and reviewed by the independent review team.

Results

All except one LPC completed the national survey and over half of all contractors were represented within their responses. Satisfaction with both LPCs and the PSNC could be significantly improved. The main messages from the surveys were the need:

- for independent governance of both LPCs and PSNC
- to reduce variation within LPCs, improve efficiency and focus their activities
- to ensure that levy funds are used equitably across all contractors
- to create key performance indicators for LPCs to enable comparison
- to improve PSNC performance with respect to negotiation outcomes

- to develop a new national vision and strategy for community pharmacy
- to reduce LPC and PSNC committee sizes to improve efficiency
- to improve working relationships and trust between LPCs and the PSNC
- to listen better to contractors so their voices are better heard at all levels
- to appropriately resource PSNC to enable staff to better support negotiations and LPCs

Discussion

Whilst there were many examples of good practice and innovation across the network, significant variations in performance and governance were identified. Satisfaction at all levels, PSNC, LPC and contractors could be improved.

It was ubiquitously recognised that the PSNC executive team has been under resourced for many years with respect to the negotiating process and supporting LPCs generally. The COVID-19 experience further evidenced this. To improve performance within negotiations there were repeated requests for a more effective negotiating team, who are extensively trained, prepared and supported for the role. We therefore strongly recommend that increased funding for the executive and an employed negotiating team is a priority.

There is a clear need and support for an oversight governance body which is accountable to contractors. With a remit to improve performance, communication and transparency across the network, we believe that this should also be a priority consideration.

The structures used by the General Practitioner Committee and Community Pharmacy Scotland are very effective and therefore our main recommendation for consideration is to replace the current PSNC Committee with a national council of LPC chairs. Placing LPCs at the centre of decision making should ensure that both theirs and the contractor voice are more effectively heard in all negotiations. A better supported national network with an overarching governance body and framework, should reduce the routinely reported duplication and variations in practice. The COVID-19 experience demonstrated the value of LPCs having a direct line of communication with the PSNC executive team and the value of a more formalised national network. We would anticipate that all LPCs represented on the council would voluntarily sign up to the new governance structure and framework.

There was a repeated demand to centrally set up a human resources department, finance support team, provider company, service template and evaluation centre and an external communications team. We suggest that a new national council should consider each of these as they are likely to enhance performance, reduce duplication and variation within the system and thereby improve value for money for contractors. There was a common belief that efficiency gains from LPCs could fund the new model. These could be achieved through smaller LPCs merging or federating. reducing the size of committees and moving more activities to online platforms. We estimate that the cost of all these changes may require between £1.5M & £2.2M extra funding per year or £21k to £32.5k additional levy per LPC depending on the extent of recommendation adoption.

The first action of the national council and governance body should be to develop a national strategy for community pharmacy and achieve that ‘one voice’ repeatedly identified as necessary. In recognising the broadening of role, we propose that the newly structured PSNC is named Community Pharmacy England (CPE), the national council Community Pharmacy England Council (CPEC) and LPCs Community Pharmacy ‘Local name’.

2. Recommendations

(Priorities highlighted in blue)

Names

1. Rename PSNC committee and executive as 'Community Pharmacy England (CPE)'
2. Rename all LPCs to "Community Pharmacy [locality] (CPL)".
3. Remove the term 'Chemist' from all documentation where possible and replace with 'Community pharmacy or pharmacist' as appropriate

Governance

4. **Create an independent Community Pharmacy England Governance and Strategy Board responsible to contractors for oversight of CPE and CPL**
5. Develop a governance framework to include a code of conduct for all members, Key Performance Indicators, expectations regarding transparency and communication
6. Constitute for a regular independent review of whole system
7. Limit membership for all committees to 12 years (three terms of four years)
8. Ensure that the Chair and employee roles are separated
9. Only allow elected contractors and nominated contractor representatives to have voting rights

Community Pharmacy England Non-Executive

10. **Create a national vision and strategy for Community Pharmacy in England**
11. Develop and implement a national communication strategy to enhance external perception of Community Pharmacy
12. Create a Negotiating team (NT) consisting of contractors and contractor representatives which is employed and extensively trained by CPE
13. **Replace the current PSNC with a CPE Council (CPEC) constituted by Chairs from CPLs each representing an agreed minimum number of contractors.**
14. Create negotiation policy development groups from CPEC designed to consider all aspects of community pharmacy within the negotiation process
15. From the CPEC create a smaller Negotiation Strategy Committee (NSC) to respond to day to day negotiation questions from the Negotiating team
16. Develop strategies for including patient and public representatives in all elements of CPE

Community Pharmacy England Executive

17. Create support centres for CPLs and CPE including a human resources department, finance team, external facing communications team, national provider company and Community Pharmacy Integration Centre.
18. Develop an effective network for CPL Chief Officers to enable sharing of good practice and to provide peer support.

Finances

19. **Significantly increase funding to CPE to support the negotiation processes and LPCs**
20. Arrange for the levy to be directly paid to each of CPE and CPLs
21. Create a CPE transformation fund
22. Seek external funding, where appropriate, to support PSNC transformation to CPE and the set-up of proposed support bodies

Community Pharmacy Local

23. Review CPL size with respect to number of contractors represented, considering value for money to contractors, size required for a place on CPEC, local knowledge/relationships and NHS geographical footprints.
24. Reduce CPL committee sizes to maximum of 10 members whilst maintaining local proportional representation.
25. Increase the use of virtual technology to improve value for contractors
26. Identify and implement effective approaches to engaging with local contractors.
27. Provide honoraria for all members of CPL committee to compensate for time taken to deliver roles effectively and improve engagement
28. Allow pharmacy employees and patient and public representatives to have non-voting membership of CPLs
29. Provide on-line training to all CPL members on their roles and responsibilities, GDPR, Equality and Diversity and recruitment and appointment as appropriate
30. Review processes and create strategies to ensure that all employee appointments are fair and transparent and that CPL are equal opportunity employers.
31. Develop strategies to ensure that engagement by all CPL committee members is equal
32. Focus levy funded activities on representative rather than support related activities
33. Negotiate and set up new services only where there is a reasonable profit margin

3. Explanation for recommendations

A fuller discussion of the results, providing greater detail is provided at the end of the main report.

Governance

Throughout, there was clear evidence of innovation emanating from within LPCs and PSNC committee and executive members working beyond expectations and reasonable working hours. However, a lack of independent external governance for both the PSNC and LPCs and significant variation in delivery and outputs by LPCs were the first strong messages to derive from our data collection. Satisfaction with different LPCs by contractors was clearly variable with some LPCs performing well and others less so. The review of LPC websites found that almost one third of LPCs had not posted a financial report in the previous 12 months and that only a very small proportion provided an up to date self-evaluation of governance. Without annual reports and financial accounts being publicly available it is unlikely that contractors within those LPCs have any understanding of how their money is being spent, the quality of the service being provided and whether they are receiving any value for money.

There was also reported mistrust of the voting behaviours of some PSNC members. With the first annual report from PSNC in many years being delivered in 2019, it is clear that better governance is required not just within LPCs but also within PSNC.

The current structure of PSNC and LPCs is such that they do not directly answer to anyone and therefore are not required to publish up to date information on their performance or how the levy was being spent. It was not surprising that contractors expressed frustration that whilst they paid their levy they were frequently very much in the dark with respect to how and what it was being used for. Furthermore, they were clearly dissatisfied with the current national contract, which the levy is paid to optimise.

Over two thirds of LPCs and many of the PSNC members supported the introduction of an independent governance body who would be directly accountable to contractors. We therefore propose that one of the first actions should be to constitute an independent governance body which overarches all local and national activities, answers to contractors and that is responsible for development of and monitoring against a governance framework.

We suggest that training on topics such as GDPR, equality and diversity and interviewer training should be a requirement within any governance framework as training of this nature reduces 'risk' within the system and therefore minimises the opportunity for loss of levy due to preventable mishaps.

Similarly, differences in the operation of Chairs within committees, means that 'on appointment' they and all LPC members should all be expected to access training to understand what is expected of them and to ensure that they recognise their role in ensuring good governance.

We found that in some LPCs the LPC Chair and Chief Officer (CO) were the same person, and in others the Chief Officer was a voting member of the LPC. None of these practices can be supported within a governance framework whereby the CO is an employee and responsible to the representatives of contractors i.e. the LPC. Similarly voting rights on LPCs should only

be given to those members who are nominated or elected into that position. Survey responses strongly supported this stance and again we believe that any governance framework should ensure that LPCs adhere to such expectations.

Whilst we see no reason why non-contractors and patients could not be associate members of LPCs and see good reasons for doing so, there was no strong support for them to receive voting rights. Again, whilst we have proportional representation on LPCs between different contractor groups, we do not believe that it is appropriate to extend voting rights beyond this group.

There was also significant agreement that the introduction of published key performance indicators (KPIs) would help to focus activity and reduce variation in practice and performance. Whilst KPIs surrounding negotiating new local services were recommended, it was noted that new services should not happen unless there was a reasonable profit margin within them. Work creation with no obvious benefit to contractors is not appropriate in the current climate. Consequently, appropriate negotiation skills training should be made available to LPC COs and Chairs.

During the review we heard a small number of stories of alleged bullying, harassment and generally poor behaviours involving COs, Chairs and committee members from LPCs. The model LPC constitution states that any complaints of this nature should be handled within the committee itself. With many of the stories involving members of the same committee this does not seem to be ideal, providing protection to no one i.e. the accused or accuser. Whilst such incidences are likely to be rare they can be costly to the network if mishandled. Consequently, in addition to an external body providing governance, it may also provide a conduit for whistle blowers and for independent arbitration when such disputes occur. These experiences, if nothing else, supported the need for a reviewed code of conduct for all LPC and PSNC members which is enforceable. Again this was supported by PSNC members, LPCs and contractors alike.

A number of instances which occurred during the review process identified splits in LPCs between contractors and contractor representatives with respect to engagement and attitudes by Chairs and CO. We therefore believe that some thought and effort must go into developing strategies to better balance attitudes towards both sides from COs and Chairs but also to better integrate the committees such that differences in employer are less obvious. The culture clearly needs to shift to focussing on what is best for community pharmacy as a whole rather than different employers or individuals within it and leadership with respect to this must come from chairs and COs.

We asked questions regarding diversity and representation within LPCs due to the repeatedly raised concerns regarding whether they truly represented their contractors. Whilst the majority of respondents believed that LPCs should represent the diversity within their population of contractors, many disagreed because they did not believe in 'tokenism', 'positive discrimination' or 'quotas'. We do not agree with any of those concepts either. The question is whether appointment and election processes are seen as fair, open and whether any facets in the role itself unconsciously discriminate against any groups i.e. make it less attractive to apply. Positive action, through the setting of targets for individual groups identified as under-represented within the network, is however appropriate.

Working to make committees represent the diversity in their local population is about providing a level playing field and an environment where there is acceptance of anyone irrespective of any protected characteristics. We frequently heard of people being approached to join committees and committee meetings all being held in the evening. Neither of these are good examples of providing a level playing field. Consequently, as part of the governance requirements for LPCs, we recommend that they should all undertake a review of their processes to ensure that membership is equally attractive to all and that all employee appointments are designed to recruit the best candidates. We do however recognise that a proportion of LPC members are appointed by CCA and AIMp and that this process is currently managed in-house. At this stage we are not recommending removal of this process but will suggest that the independent governance body seeks clarification from CCA and AIMp with respect to their processes to ensure that they meet the same criteria.

A reason for the male dominance on committees was frequently cited as due to men being more likely to own contracts. Whilst we believe this is likely to be true, with no limit to the number of terms on an LPC, the committee could very easily represent the contractor population from 10 to 20 (if not 40) years ago. Whilst LPCs resoundingly voted against limits to numbers of terms for members, contractors were evenly split, with many citing the need to allow younger people onto the committees and to 'shake things up'. The term 'stale' was used to describe the system (LPCs and PSNC alike) and we believe that the lack of turnover for some members contributes to this perception.

Although standard governance recommendations are three terms of three years we do not believe that this would be appropriate at this time as this may decimate some LPCs and create significant instability at a time of transformation. Furthermore, we heard many stories of LPCs struggling to attract members and therefore rapid regular turnover may create additional difficulties and uncertainty. Consequently, we recommend that a maximum number of terms should be set for committee members but taking into consideration the fact that some LPCs currently struggle to attract members and may be negatively affected by it. There was not strong support for limiting Chief Officer terms and this seems appropriate providing appropriate governance procedures are in place and they are appropriately performance managed.

Local Pharmaceutical Committee Structure, Size and Activities

Participants at all stages supported the concept of local pharmaceutical committees, citing the value provided by having a local voice for pharmacy within relevant healthcare and local authority systems, their ability to seize opportunities to enable greater local contractor engagement and consequently the fact that all community pharmacy service innovations have been derived from them. The ability of LPCs to respond in such a positive and rapid manner during COVID-19 through effective representation of the interests of contractors is further testament to their value. There was a clear desire for this network to be protected and therefore our report and recommendations are made with this at the centre of our considerations.

There was, however, recognition throughout the process that efficiency of LPCs could generally be improved and that this could be achieved with fewer and smaller committees and by LPCs representing more contractors. There was also a view that, whilst everyone recognises the fluidity of NHS structures, alignment with Sustainability and Transformation

Partnerships or Integrated Care Systems is probably appropriate at this current time as they are likely to remain for a number of years. The importance of maintaining local relationships was ubiquitously also seen as important as was the point that different geographies required different solutions.

The evidence showed a clear drop in average levy for contractors when LPCs represent 200 or more contractors and that all LPCs whose levy is currently above that seen by larger LPCs should consider how they could potentially reduce their levy to better align with them. Such decisions are clearly up to the LPCs but we suggest that the current variation in levy size dependant on geography should be reduced to ensure better value for contractors.

The COVID-19 experience has already moved LPCs to meeting via electronic methods and therefore we expect that there will be significant savings with respect to reductions in travel costs and room hire. This will not only be seen within the LPC committee but also through COs who will now be expected to undertake many of their activities on-line and through the greater use of on-line events for contractors.

After considering all of the evidence, most support was for representation activities to be levy funded and that patient and public involvement should be included within this. Some of the LPC 'support services' were seen as providing preferential treatment to one contractor group over another. We therefore believe that in order to ensure best value for all contractors, it is important that LPCs review the current activities they undertake with levy funding to ensure that they are focussed on representation. Services to 'support' contractors, should be funded from outside of the levy. For example, where events are required to prepare contractors for set up and delivery of new national contracts we propose that the cost is covered within the national contract itself.

We do not want to stifle innovation that comes from LPCs or to prevent them from undertaking any activities they believe are appropriate. Variation of this nature is clearly important to stimulate change within the profession.

Contractors frequently complained that their voice was not heard and that neither LPCs nor the PSNC represented them. Consequently, we believe that, where necessary, LPCs need to work harder to listen to their contractors. Again, approaches to improving the ability to listen to contractors need to be tested, with those found to be effective shared across the network. Annual General Meetings are not seen as well attended and perhaps better use of social media and online software may be more appropriate approaches to enhancing contractor engagement.

With all of the LPC activities and innovations heavily dependent on COs it is perhaps of no surprise that a request for setting up a network to better enable sharing of good practice and to support them in their roles, which can be relatively isolated, was made. This had to be something different to the current social media-based Gaggle Mail group (a simple shared group email platform) where the loudest voices are heard and it is more about expressing opinions than sharing ideas and supporting each other. The value of such a network was readily identified within the Rapid Action Team involved in responding to the COVID-19 crisis. The regional representation and networks set up by COs as a result may form an effective model for the future larger network.

The size of LPCs with respect to committee members was extremely variable and we could see no reason why they should have greater than 10 voting members, particularly given the fact that the committee itself was frequently the major cost within an LPC. There was agreement across the board that once a committee goes beyond 10 members it becomes difficult to manage. Recognising that 10 creates a committee which could result in hung decisions however, in such circumstances it is appropriate to give the deciding vote to the chair.

Reducing the number to ten should prevent members from 'hiding from their commitments' and all should be expected to make a full contribution. Variable engagement by LPC members was frequently cited as a concern. Reducing the number of members should also reduce the pressure to identify so many individuals locally. To improve engagement, encourage recruitment and members to prepare for meetings we also suggest that LPCs consider paying honoraria to all members. This would need to be dependent on their engagement with the LPC and not just a payment for being a member.

New PSNC Structure

The distance between the PSNC and LPCs with respect to trust and listening to each other was repeatedly identified as a problem both by PSNC and LPC members. The COVID-19 experience very clearly demonstrated the benefits of much closer working between the two. The regional representative system, whereby independent contractor members of the PSNC reported to all LPCs in their region, was seen to be variable with respect to effectiveness and wholly dependent on individuals who were largely delivering the role in their own time. The hard work put in by regional representatives was however noted and appreciated. The rationale for the regional boundaries is however historical and seen as too large to be effective. The fact that PSNC regional representatives, de facto representatives of independent contractors, were the only avowed direct link between LPCs and PSNC sent a subliminal message to local committees about the relative importance of independent contractors compared with other contractor representatives.

We were taken by both the GPC and Community Pharmacy Scotland models, whereby the central/national negotiating teams were constituted by their local committees, thereby removing any distance between the two. Whilst recognising that funding within Scotland for the NHS is greater than in England and that GPs do not have the same complexity within their systems as community pharmacy, both committees have been very successful in negotiating successful contracts for their contractors. Their models seem to address many of the concerns identified within the current PSNC/LPC system. By placing LPCs at the centre of all negotiation strategy with government, it removes the perceived secrecy which was frequently alluded to with respect to PSNC activities, better enables LPCs to see how government operates and also provides a much more direct line of communication from contractors through to policy making and national negotiations.

The COVID-19 experience clearly demonstrated the potential benefits of moving towards this model but still resulted in a number of LPCs resisting requests from the PSNC as they were not directly part of the Rapid Action Teams. By locating LPCs at the centre and embedding representatives throughout any new structure this should completely remove the 'them and us' perception and provide complete ownership of the system by LPCs.

Consequently, therefore, the main recommendation for the review is the replacement of the PSNC committee with an LPC Council. Our recommendation is that this council would be constituted by LPC chairs who are elected to their role and are either contractors or contractor representatives. To be a member of the council the chair would be expected to voluntarily sign their committee up to the overarching governance framework, thereby providing an incentive for engagement with this process.

From the LPC council a Negotiation Strategy Committee (NSC) would be derived who would respond to day-to-day questions and problems surrounding the negotiation process. This model also allows the NSC and NT to go back to the LPC council with the government's offer to allow them to vote on it. This was repeatedly seen as something that GP contractors could do but did not occur currently in community pharmacy.

We propose that the Council should consist of no more than 50 members to enable discussion to be manageable and again, similar to the GPC model, to have a voice at the centre each member has to represent a reasonable number of contractors. Circa 200 would seem be appropriate given the change in levy fee at this point and would probably provide the required number of committee members. However, this decision needs to be made by the LPC chairs when forming the council. The additional advantage of setting a minimum number of contractors on the council would ensure that all chairs had a reasonably equal voice and those representing larger LPCs would not dominate on this basis.

Whilst recognising that all recommendations have been to reduce committee size for effective working, the LPC council is a 'council' and would not be expected to operate as a committee. Its role would be to discuss and debate major issues, listen to and contribute to plans from the policy groups and vote only on major issues such as whether to accept the negotiated contract.

To ensure that the Council was able to provide regular input into policies to underpin negotiations, we propose that the Council meets regularly throughout the year. This should be predominantly via on-line methods, with the location of any face to face meetings rotating around England to remove the accusations of London centricity within the current system.

With the additional responsibility for Chairs associated with attending and preparing for national Council meetings, we propose that they are remunerated to cover the time required to deliver their responsibilities. This however could be partially, if not fully covered by the budget which is held by the PSNC executive team to cover current PSNC committee member time.

We recognise that current Chairs have not signed up to a national representation role and may not have the capacity or desire to undertake this. This however should not be a reason not to move LPCs into the centre, if this model is believed to be better for contractors. It means that effective succession planning locally is required and that the new chair responsibilities need to be fairly presented to enable other individuals to step in to such a role. This cannot happen overnight and consequently we believe that such a council would take at least two years to be fully operative. In the interim however current Chairs can work with the transformation team to develop the governance framework and agree the vision and one voice for community pharmacy.

The new model would require Chairs to be in place for a number of years to enable them to effectively engage with central council and therefore the current model of voting for the Chair on a yearly basis would no longer be appropriate.

Whilst we recognise that this recommendation effectively closes down the PSNC committee as we know it, this should not be seen as representing any criticism of any individual PSNC members themselves. We found them all to be extremely conscientious and passionate about community pharmacy. We also recognise the significant amount of unfunded work carried out by regional representatives who tirelessly and charitably travelled across their regions in their own time to create the bridge between the PSNC and LPCs. However, we believe that, from the evidence we have collected, the current structures, within which they operate, will not provide the best value for contractors going forward.

Policy groups

The GPC model of policy groups, derived from their central council/committee, which focussed entirely on informing the negotiating process, seemed much cleaner than the model of sub-committees within PSNC. Currently they assume a variety of roles both within and outside of PSNC and do not seem to consider all elements of community pharmacy practice. We therefore propose that a number of policy groups could be derived from the central council and their focus decided as part of the transformation process and would change depending on current priorities.

A persistent concern regarding how the PSNC operated, was that it relied solely on the expertise within the committee and not bringing in appropriate external expertise when they could provide additional and different perspectives to discussions. This lack of using others was also seen as part of maintaining secrecy with respect to PSNC actions. We therefore recommend that policy groups do not rely entirely on LPC Chairs but are encouraged to add members from outside as they deem necessary either in fixed term posts or as occasional visitors.

Negotiation Strategy Committee

With the PSNC committee recognised as being too large for effective working and responding to rapidly changing negotiations, we suggest that a Negotiation Strategy Committee is derived from the national council. This should be much smaller and well informed by the policy groups, potentially being populated with their chairs. As such the NSC members would be consulted with by the negotiating team as negotiations progressed with the full council consulted as appropriate.

The models in Wales and Scotland have been set up to remove the need to consider proportionality with respect to multiples and independents on their negotiating committees and teams as there is a clear expectation that all members vote in the best interests of community pharmacy. We however realise that there is a need to ensure that all groups' interests are appropriately represented and consequently we would recommend that careful consideration is given to the constitution of the NSC to ensure that independents, AIMp and CCA are all represented appropriately at this level.

Similar to the GPC model, once a negotiation round was completed, we would like to see the negotiating team and NSC take the decision to the national council for ratification.

Negotiating Team

A need to improve outcomes from national negotiations and to train the negotiating team (NT) was repeatedly stated in all parts of the review. Concerns were raised regarding divisions within the current negotiating team and the lack of an overarching negotiation strategy when entering into negotiations themselves.

We again liked the GPC model for their negotiating team. They employ four GP contractors from their LMCs to work 2 days per week as negotiators. These are carefully selected, extensively trained and supported to work as a team.

We would expect all of their actions to be underpinned by the CPEC policy groups and as such they would work in partnership with the NSC. As employees and for governance purposes it would however be appropriate that the CEO of PSNC assumes responsibility for the NT.

Centralised services

The word 'duplication of effort' was used routinely throughout the review. In response to the need to reduce duplication and increase efficiency, thereby providing better value to contractors, there is a clear need to centralise certain elements that are generic between LPCs and PSNC within the system. Similarly, LPCs identified a number of things for which they would like central support, including human resources, treasurer and finance support, development of national templates, support and guidance for the delivery of evaluations and a national provider company. We agree that all of these functions could be delivered centrally to support LPCs, reduce duplication and variations in practice and therefore improve value to contractors. With LPCs central to the national body they would be in a better position to inform their structure and ways of working. Consequently, with greater ownership at this level LPCs may feel more comfortable with greater centralisation of service than has previously been the case.

Human resources department

The lack of a human resources department in PSNC and recommendations to LPCs to purchase this element externally, identified an area of potential risk for all employers in the system. Evidence from all data sources in this review suggested that employment practices could be significantly improved and centralisation of such a resource would service both elements well. It would also be able to provide advice with respect to managing underperformance, appropriate pay scales for different activities and how to reward and incentivise performance which exceeds expectations.

We were also struck by reports of how LPC COs were appointed (from interview in a public house with the Chair, interview with Chair, Vice Chair and treasurer to interview by the whole LPC) and the fact that salaries could, pro-rata, exceed £100k. The review has made it very clear however, how important the CO is to the success of the LPC. Consequently, along with the majority of LPC respondents, we believe that such appointments should be made in a standardised manner such that LPCs could not be accused of any unfair practices. To support and standardise this further it may be appropriate for national guidance to be created with respect to what an appropriate remuneration package for a CO may consist of. All of these responsibilities could fall within a centralised human resources department.

Finance department

LPCs requested more central help and guidance with respect to managing their finances and we believe that this again is an area where some efficiency gains could be achieved through the setting up of a central finance team to provide this.

The new central finance team (separate to the policy finance group) who would have good oversight of the whole PSNC/LPC budget would additionally be responsible for agreeing the proportion of funding to be delivered centrally and the amount to be delivered locally. This would be signed off by the LPC council on a yearly basis.

Communications

We additionally agree with those contractors who stated that there was a need for a larger central communications team to build public and government recognition of the value of community pharmacy. The Communications team within PSNC are already working more broadly with this agenda but currently there are insufficient resources to take this forward. Increasing public and government awareness of the positive contribution that community pharmacy makes to national health, will ultimately strengthen the position of the Negotiating Team. Consequently, we believe that a communications team with a broader remit requires constitution. The COVID-19 experience and potential for greater positive stories regarding the role of community pharmacy would be fully capitalised by such a team.

We believe that LPCs would be central to delivering this agenda as communication needs to be both at local and national levels, consequently we recommend that all LPCs employ someone with a communications responsibility.

Community Pharmacy Integration Centre

There was extensive evidence of similar services being set up by different LPCs and at each point a new service specification is created. Similarly, it was noted that the quality of associated evaluations which provide evidence for service continuation and expansion to a national level are frequently either non-existent or insufficiently rigorous for effective learning to take place. Of perhaps greater concern is that the evidence does not enable the service to be recommissioned.

The term 'pilotitis' was used a number of times and clearly there is excess duplication within the system with respect to new service development. Furthermore, there seemed to be limited sharing of learning across LPCs. Centrally it has already been identified that using local service specifications to develop national ones, which can then be shared across the network, would increase both efficiency and quality overall. However, again, there is currently insufficient resource within the system to enable this to happen.

We therefore suggest that the creation of a service development and evaluation centre potentially named the 'Community Pharmacy Integration Centre' is considered. Named in recognition of the need for community pharmacy services to be better integrated into NHS systems and clinical pathways. The centre could be responsible for creating national service specifications based on those already created within LPCs, to support LPCs to create new service specifications to trial in their area and to support design and analysis of all evaluations.

To optimise service design, it would be appropriate to liaise directly with the newly created Chief Officer network to obtain feedback and guidance on central service specifications and enable sharing of good practice.

To maximise acceptance of all new services and effectiveness of evaluations, the Community Pharmacy Integration Centre could also benefit from an advisory board consisting of representatives from patient groups, GPs, NHS E&I, community pharmacy stakeholders, the Pharmacist's Defence Association and Royal Pharmaceutical Society. We suggest however that funding for the Community Pharmacy Integration Centre should be sought from the Pharmacy Integration Fund (PHIF) rather than levy from contractors.

If such funding was not forthcoming, then the resource required to enable centralisation and standardisation of service specifications should be sought through the levy.

National Provider Company

Local experiences of setting up 'provider companies' to support management of contracts with multiple providers were reported as variable, ranging from setting up and closing such companies down, setting up companies and finding alternate routes to make them profitable e.g. setting up a buying group, to finding ways to circumvent the process altogether. These experiences probably explain the calls for a national provider company within some responses from LPCs.

We also note that the Local Optical Committee Support Unit initially set up a provider company for each of their Local Optical Committees but found that, due to variation in usage and need, it was more efficient to set up a national provider company. Their one regret was not starting with a national provider company in the first instance.

We therefore suggest that within the transformation the setting up of an 'arms-length' national provider company is considered.

Patient and public involvement

Whilst the NHS works to the mantra of 'no decision about me without me' and seeks to include the patient voice in all NHS activities, we noted that the patient voice was limited within the set up and development of community pharmacy services. The only current routine patient and public involvement within community pharmacy is the yearly service satisfaction survey.

A frequent misunderstanding with respect to using patient and public involvement (PPI) representatives is that they are real patients with little or no understanding of NHS systems and processes. Our experience, as researchers where we have long worked with PPI, is that they can be anyone with a passion for representing the patient voice and many of such individuals are incredibly eloquent and passionate about enhancing patient care.

There is nothing more powerful in a meeting with the NHS than the voice of a patient representative. Therefore, we believe that LPCs and the PSNC would benefit from greater patient and public involvement throughout. This can range from the design of new services, involvement in the development of communication strategies through to supporting the national Negotiating Team.

LPCs could, for instance, set up patient advisory groups to support their community pharmacists and inform the development and design of new or current services. We therefore recommend PPI strategies are developed and tested throughout the system. Those which are found to be most effective being shared and implemented.

Funding

There was strong evidence and complete agreement that the PSNC executive are under resourced and that significantly more resources were required to enable them to appropriately support national negotiations and LPCs. This problem was unfortunately highlighted by the COVID-19 crisis where executive team members (and LPC Chief Officers) were routinely working 14 hour days. Even when generous offers of help were made by bodies such as the CCA and NPA, these could not be fully taken up. For individuals to be effective they need to know the local systems and processes and be fully aware of who to be contacted for what. This knowledge takes time to acquire, time which is not freely available in a crisis situation. Consequently, if nothing else results from this review, LPCs must as a priority identify additional funds to support the activities of the PSNC executive which underpin all negotiations and support activities.

With the national negotiation providing the greatest benefit or harm to contractors it seems strange that the funding for this is currently at the behest of LPCs with some of them occasionally withholding payments and causing uncertainty with respect to the executive's finances. This therefore creates significant risk for the contractor.

With a central LPC council embedded within and central to the national structure, we would no longer see the need to funnel funding to the centre through LPCs in the current manner and that it could automatically be split at source. The national Council could provide oversight and sign off to the eventual distribution of funds, thereby ameliorating any concerns regarding such an arrangement.

What is clear, is that if the review's findings are largely accepted and implemented, then with the current PSNC executive already overstretched, the transformation will require a budget to enable it to be delivered in time for the next significant national contract review in four years' time.

It was interesting to note that whilst the PSNC recommends that LPCs should hold the equivalent of half their annual income in reserve, there is evidence from the website review that the average was significantly greater than this. In fact, almost double if the average per LPC is circa £150k. The data suggests that LPCs are currently holding up to £4M more in reserve than is required. We recommend that some consideration be given with respect to how to best spend this on behalf of contractors and that CPE and CPL transformation may be an appropriate cause. Where possible, however, funding should first be sought externally for any such activities as this would enable more resource to be retained for contractor representation.

One voice

The need for one voice for community pharmacy and an agreed new national strategy and vision to inform negotiations was regularly identified throughout the review process. The fragmented voice of community pharmacy was seen as a major weakness within the

negotiating process and if the NT could enter this knowing that they had the full support of all parties then this would significantly strengthen their position

It was also recognised that a national strategy that was developed without listening to the main customer, the NHS, was unlikely to be effective.

Development of this strategy could fall within the remit of the overarching governance and strategy body providing that it was appropriately constituted to ensure that all stakeholders are included within it. The national council of LPC chairs would also need to be central to any such process.

New names

The expansion of role, of what was the PSNC, beyond the pure negotiation process and into creating an environment to support it, requires recognition within the name. We therefore propose that new LPC council, NSC, NT, Governance and Strategy body be named as a whole, 'Community Pharmacy England (CPE)'.

Furthermore, in line with a move made by a number of LPCs already, LPCs should all be renamed Community Pharmacy 'local geography (CPL)' and the LPC council at the centre of all of this 'Community Pharmacy England Council (CPEC)'.

We believe that these names would be seen far more positively by people outside of LPCs and PSNC and that they describe accurately who the committees represent. Consequently, a significant rebranding exercise would be required.

Finally, one thing which surprised us within every document we read which has been provided by the PSNC and LPC with regard to constitution and rules, was the consistent use of the term 'Chemist' to denote 'Community pharmacy or community pharmacist'. This seemed antiquated and completely inappropriate in a time where pharmacies no longer use the term in practice. Consequently, we believe that as part of the modernisation process this term should be removed, wherever possible, from all documentation and replaced with the appropriate name.

Transformation

If there is general support for the recommendations, then an implementation plan will need to be created supported by appropriate resources. We suggest that the current and recently appointed independent chair of PSNC would be the most appropriate person to lead the governance of this process and that in doing so she ensures that all stakeholders are appropriately represented.

Summary

The recommendations combined with this explanation are summarised in the next section which outlines the evidence and rationale for each recommendation and impact. Again the priorities are highlighted in dark blue..

4. Recommendations, evidence, rationale and impact

(Priorities highlighted in Blue)

Recommendation	Evidence & Rationale	Impact
Names		
(1) Rename PSNC committee and executive as 'Community Pharmacy England (CPE)'	• Title better reflects role and responsibilities and will be much easier for external stakeholders to understand. • Provide a more modern image and a clear break from the current model moving forward • Aligns with Scotland, Wales and Northern Ireland	• Improved image for community pharmacy nationally • Cost of rebranding for PSNC
(2) Rename all LPCs to "Community Pharmacy [locality] (CPL)".	• Title better reflects role and responsibilities and will be much easier for external stakeholders to understand. • Provides a more modern image • A number of LPCs have already changed their titles to this model	• Improved image for community pharmacy locally • Cost of rebranding for LPCs
(3) Remove the term 'Chemist' from all documentation and where possible replace with 'Community pharmacy or pharmacist'	• Chemist is an outdated term which has no relevance to modern community pharmacy practice	• Greater recognition that pharmacists are healthcare professionals
Governance		
(4) Create an independent Community Pharmacy England Governance and Strategy Board responsible to contractors for oversight of CPE and CPL	• Strong support for independent governance from LPCs and PSNC members • To monitor performance of CPEC and CPL • To provide an independent body to resolve disputes and behaviours outside of expected standards	• Provide independent oversight of network to encourage better governance • Provide independent support for internal dispute resolution • Support for national roll out of changes to contracts at a national level

	• To develop one vision and voice for community pharmacy in England • To support activities across CPE • To support response to contract changes	• Additional cost associated with inclusion of non-executive directors
(5) Develop a governance framework to include a code of conduct for all members, Key Performance Indicators, expectations regarding transparency and communication	• Evidence of duplication and variations in practice • Lack of transparency from some LPCs evidenced by lack of published annual reports, financial statements or internal governance review	• Improved transparency at all levels for contractors • Reduced variation in practice • Reduced duplication • Improved and focussed performance
(6) Constitute for a regular independent review of whole system	• Initial negative response to review and suspicion demonstrated lack of culture of review within the system • A number of recommendations require review as are designed for the current system	• Continuous and ongoing improvement for system
(7) Limit membership for all committees to 12 years (three terms of four years)	• Corporate guidance recommends no more than three by three years for membership of boards of this nature. • Support from contractors for this as recognised need for regular change. • Majority of respondents agreed that committees should reflect the diversity of contractors. Members who have been on CPLs for substantial periods of time will reflect the diversity from when they joined. • Need to enable younger members of the profession to become engaged in local politics and bring a fresh perspective	• LPCs will need to plan for replacement once a date for implementation is agreed • Enable CPLs to naturally shrink to 10 members

(8) Ensure that the chair and employee roles are separated	• Evidence that some LPC chairs are assuming employee roles within LPCs • Good governance denotes that the chair is a non-executive role designed to manage the executive team and their performance. Consequently this represents a conflict of interest	• Better governance processes within some LPCs • A small number of LPC chairs required to decide which role they wish to continue with
(9) Only allow elected contractors and nominated contractor representatives to have voting rights	• Evidence from surveys strongly supports this as contractors pay for CPLs and PSNC • Evidence that some employees currently have voting rights which is not appropriate for governance	• Impact on small number of CPLs which allow non-contractors a vote • Better CPL governance
Community Pharmacy England Non-Executive		
(10) Create a national vision and strategy for Community Pharmacy in England	• Although 'Pharmacy Voice' developed a national vision and strategy for community pharmacy this is no longer in the national consciousness • Development of a vision and strategy for community pharmacy involving CPE Council and contractors would be an appropriate starting point for the new CPE • Community Pharmacy Scotland developed a strategy independently but at the same time as NHS Scotland. There was significant alignment between the two which simplified the negotiating process.	• Better understanding of the issues being faced by community pharmacies • Better understanding of community pharmacy plans externally i.e. by NHS England, other healthcare professionals and patients • Improve focus with respect to local and national activities • Strengthen and underpin national negotiating strategy
(11) Develop and implement a national communication strategy to enhance external perception of Community Pharmacy	• Repeated calls for better presentation of community pharmacy in the media to strengthen negotiating position both locally and nationally	• To improve community pharmacy representation in the media and raise the role in national consciousness

	• PSNC Communication lead has plans for national strategy and is working with all leading partners to develop this, however lack of resources is preventing implementation.	• Negotiation strengthened through positive presence in the media and greater patient and public support • Increase cost for development of national community pharmacy communication strategy • Requirement for communications officer in all CPLs • Additional cost for increasing Communications staff centrally
(12) Create a Negotiating Team (NT) consisting of contractors and contractor representatives which is employed and extensively trained by CPE	• As per GPC model which is effective • Repeated calls for negotiating team to be trained and supported in role • Almost continuous negotiating process necessitates need for an employed negotiating team • Employing negotiating team improves governance as they are answerable to oversight body • Evidence that current negotiating team do not operate in a cohesive manner as have different agendas and individual conflicts • Last two contract negotiations have not been well received by contractors – although there is a need to recognise that the landscape within which the negotiating team were operating was extremely difficult	• Better national contract and financial deal for contractors • Additional cost for employing, training and supporting Negotiating Team
(13) Replace the current PSNC with a CPE Council (CPEC) constituted by Chairs from CPLs each representing an	• Clear gap between LPCs and PSNC and national decision making • Clear gap between contractors and PSNC	• CPLs central to management and delivery of CPE

agreed minimum number of contractors.	• Model similar to that used by General Practitioner Committee and Community Pharmacy Scotland – both effective in negotiating their contracts • Evidence from COVID-19 experience that bringing LPCs into PSNC to work closely with them positively improves understanding, trust, communication and effectiveness. • Evidence from COVID-19 that unless LPCs ubiquitously own PSNC then a number will continue to mistrust requests from the centre • Provides an incentive for engagement with the overarching governance framework by LPCs • Setting a minimum number of contractors for representation purposes reduces disparities between the perceived power of different chairs on the council	• Clearer line of communication between contractors and national negotiations • CPLs assume ownership of CPE • Increased trust between PSNC Exec and CPLs • Removes the need for regional representatives • Some current CPL chairs may not wish or have capacity to undertake a national role. Planning for replacement required. • CPL chairs to require additional remuneration for role. Partially covered with budget for PSNC members • PSNC committee to close down when CPEC assumes full responsibilities and role. Minimum of 2 years anticipated before this occurs.

(14) Create negotiation policy development groups from CPEC designed to consider all aspects of community pharmacy within the negotiation process	• This is the model used by General Practitioner Committee (GPC) to develop its negotiating stance
	• Negotiations need to consider all elements which affect community pharmacy practice to ensure that when negotiations start there are:
	  ◦ Red lines as to what Contractors will do and what must be delivered to continue
	  ◦ A list of high-level requirements ideally all of which should be delivered
	  ◦ A list of lower level requirements which would be 'nice to have' but negotiable
		• Negotiating team to be fully aware of position, requirements and priorities of CPLs
		• Negotiations to be fully considered
		• Better and broader national contract and financial deal for contractors.

(15) From the CPEC create a smaller Negotiation Strategy Committee (NSC) to respond to day to day negotiation questions from the Negotiating Team	• A PSNC with 31 members was seen as too big for rapid efficient decision making • A NSC constituted by members of the different policy committees, possibly chairs, would be able to rapidly respond to Negotiating Team questions during negotiations	• Negotiations informed directly by CPL representatives • Negotiations perceived to be informed by one voice • NSC & NT would present final negotiation to CPEC for final vote
(16) Develop strategies for including patient and public representatives in all elements of CPE	• Services are better designed if patients are involved at the outset • Using the patient voice to inform negotiations and contract development should enhance credibility and strength of argument • Patient voice important in communication strategy	• Greater strength in national contract negotiations • Better service design and delivery • Better communication strategy • Additional costs associated with involving patient and public representatives
	Community Pharmacy England Executive	
(17) Create support centres for CPLs and CPE including a human resources department, finance team, external facing communications team, national provider company and Community Pharmacy Integration Centre.	• LPCs requested more centralised support to reduce duplication and improve efficiency • No HR function in either PSNC or LPCs. This provides significant risk within the system and has resulted in LPCs paying for private companies to provide this for them. • Financial transparency by LPCs could be enhanced • Recognised need to improve public perception of community pharmacy through better external communications and that this needs to be a joint venture with all stakeholders • Evidence of provider companies being set up locally but some not being financially viable and others closing down	• Improved quality of staff contracts and management. • Reduced risk with better employment practices • Support CPLs to provide greater financial transparency • Standardised service from national provider company for LPCs when commissioning local contracts • Improved public perception of community pharmacy enhances negotiating team strength and effectiveness • Reduced duplication with respect to new service introduction via availability of national templates

	• Evidence of need for provider company for community pharmacy but demand is variable and therefore provision at a national level safer financially • LOCSU model started with local provider companies but eventually moved to a national model for reasons above • Evidence of many LPCs duplicating service introduction and development. Strong belief that local service templates should be shared and amalgamated. Currently insufficient resource within the system to support this although need recognised within PSNC employees and survey results. • Evidence that the quality of service evaluations could be enhanced	• Better and more effective models for service implementation • A stronger evidence base for new services would improve outcomes from local and national negotiations • Additional cost for creating centralised services • Reduced local costs for employing private HR companies.
(18) Develop an effective network for Chief Officers to enable sharing of good practice and to provide peer support.	• COVID-19 demonstrated the value of a Chief Officer network through reduced duplication of effort and the recognition and improved use of expertise within other LPCs • Gaggle group not seen as a supportive environment and communication within it reduced by introduction of network	• Better local service design • Better informed local negotiations • Better local problem resolution • Greater job satisfaction for COs
	Finances	
(19) Significantly increase funding to CPE to support the negotiation processes and LPCs	• Strong and compelling evidence that the internal team is significantly under resourced to undertake current activities let alone expand to enhance delivery at the national level.	• Better support for CPLs in all activities • Better support for national negotiating process • Reduced reliance on a small number of individuals to deliver the national contract

	• Centralised CPL and CPE support bodies will require additional funding	• A greater proportion of the levy will need to be contributed to CPE
(20) Levy to be paid directly to CPE and CPL rather than via CPL	• CPLs will be central to CPE and therefore the rationale for cycling money through CPLs to CPE is removed • The proportion to be paid centrally and locally would be proposed by the central finance team but only implemented if signed-off by CPEC	• Greater security for CPE • Reduced risk for contractors with respect to the national contract negotiation
(21) To create a CPE transformation and development fund	• Significant initial costs associated with the three-year transformation plan recommended here • No additional capacity within PSNC executive to deliver this	• Creation of new more effective national and local networks • Potential additional cost to LPCs and contractors
(22) Seek external funding, where appropriate, to support PSNC transformation to CPE and the set-up of proposed support bodies	• The NHS holds funds to support transformation processes • The Pharmacy Integration Fund was set up to support better integration of pharmacy into the NHS	• Reduced final cost to the contractor
Community Pharmacy Local		
(23) Review CPL size with respect to number of contractors represented, considering value for money to contractors, size required for a place on CPEC, local knowledge/relationships and NHS geographical footprints.	• Clear support for rationalisation of the network to free resources for more local and national activity • Main fixed costs are employees. Committees consequently either merge or better share resources to increase efficiency • Evidence that levies are lower once the number of contractors represented by an CPL passes 200	• More efficient CPLs • Resources freed up to enable better national support for CPLs and more effective negotiations

	• CPE Council needs to be manageable and therefore similar to the GPC model, a place on the council needs to be dependent on number of contractors represented	
(24) Reduce CPL committee sizes to maximum of 10 members whilst maintaining local proportional representation.	• No evidence to support committee sizes larger than 10 • The committee is a significant LPC cost • Proportionality can be maintained with 10 members	• Loss of long term LPC members and institutional memory • Reduced fixed costs for CPLs
(25) Increase the use of virtual technology to improve value for contractors	• Meeting locations, travel and office space are major expenses within any organisation. • COVID-19 experience has demonstrated that greater use of technology allows meetings to be undertaken virtually, reduces the need for travel and for office space • Virtual meetings enable pharmacists to remain in their workplace and removes travel time.	• Improved CPL (and CPE) efficiency • Better value for money for contractors
(26) Identify and implement effective approaches to engaging with local contractors.	• Contractors reported not being listened to by some LPCs. The level of satisfaction with allowing contractor voices to be heard could be significantly improved. • AGMs are currently seen as the main process for reporting to contractors and potentially to listen to them. Attendance at AGMs is recognised as frequently poor and once a year to listen to contractors is insufficient. • Some CPLs reported effective approaches for delivering this and these ideas require sharing.	• Greater satisfaction reported by contractors • Better informed negotiation policy development
(27) Provide honoraria for all members of CPL committee to compensate for	• CPL Chair role is pivotal to governance of CPL and should not rely on individual good will	• Additional cost to CPLs

time taken to deliver roles effectively and improve engagement	• Evidence that engagement by CPL members is variable and again this is due to over-reliance on good will and payment only for backfill whilst in attendance at meetings. • Payment of honorariums should encourage better engagement with respect to preparation for meetings and in supporting CPL activities throughout the year.	
(28) Allow pharmacy employees and patient and public representatives to have non-voting membership of CPLs	• To enable employee and patient voices to be heard within CPL discussions • Majority of respondents agreed that CPL committees should be more inclusive but there was limited support for anyone other than contractors to have voting rights.	• Additional cost to the CPLs
(29) Provide on-line training to all CPL members on their roles and responsibilities, GDPR, Equality and Diversity and recruitment and appointment as appropriate	• Evidence that CPL members need to better understand their roles, responsibilities and liabilities to improve governance and performance • Evidence that training on GDPR, equality and diversity or interview and appointment processes is not routinely instigated or monitored within CPLs. • To minimise risk in the system it is important that all members and employees are routinely trained and kept up to date with respect to the topics relevant to their role	• Better local performance and governance • Reduced financial and reputational risk • Additional central cost to set up and refresh on a yearly basis
(30) Review processes and create strategies to ensure that all employee appointments are fair and transparent	• Evidence that appointment and employment practices within LPCs currently vary • National templates for employee roles are available but use is optional	• Better and more transparent employment practices within CPLs • Fairer and greater transparency with respect to CPL employee salaries

and that CPLs are equal opportunity employers.	• Strong support for standardising appointment practices provided within LPC survey • Non-standardised appointment practices create financial and reputational risks for CPLs • Evidence of employee salaries in some instances exceed £100k pro rata thus representing a significant fixed cost for CPLs • National guidance on appropriate salary range for all CPL employee roles would improve transparency • Need to ensure that all salaries provide value for money to contractors and those outside of the national range are justifiable • Evidence that some LPC practices regarding timings and location of meetings may dissuade applications from different groups of individuals	• Better value for contractors • Additional cost of central HR team to support standardisation and local training • Additional time required by CPL to review practices and develop a strategy to ensure that they are seen as equal opportunity employers
(31) Develop strategies to ensure that engagement by all CPL committee members is equal	• Repeated concerns raised regarding variable member engagement • Evidence of Chairs and Chief Officers positively identifying strategies to improve engagement • Evidence of Chairs and Chief Officers effectively 'giving up' on non-engaged members	• More harmonious and effective CPLs
(32) Focus levy funded activities on representative rather than support related activities	• Strong support provided for all current 'representative' roles • Evidence that CPLs are using levy funding to undertake 'support' or 'head office functions' which are seen as being preferential to independent contractors.	• More focussed CPL activity • More equitable use of levy funding • More efficient CPLs with clear remit • May result in the loss of some employed posts

	• Similarly, whilst training was seen within the remit of CPLs, it should be funded either through national or local contracts and not through the levy. • Whilst CPLs agreed that collating evidence to support PSNC negotiations was seen as important, this again should be funded either through pilot funding or nationally as it is not a core representative function.	
(33) Negotiate and set up new services only where there is a reasonable profit margin	• Evidence of services being set up locally which have no profit margin. Consequently, they add to work load with no tangible benefit to contractors. • Community pharmacies are not charities and not seen as such by the NHS. • No other healthcare professional group would undertake activities under similar circumstances • Poor negotiation outcomes devalue community pharmacy externally and set a precedent which is difficult to redress	• Contractors only undertaking activities which provide appropriate remuneration • Better value contracts for contractors

5. Current and possible proposed structure

5.1 Current structure

Figure 5.1 provides a diagrammatic outline of the current PSNC/LPC network structure.

The current link to the PSNC by LPCs is via the regional representative network which consists of the 13 independent contractors who have been voted onto the PSNC. In response to COVID-19 a Rapid Action Team, consisting of one LPC Chief Officer from each region, was temporarily set up to enable quicker and more effective communication with the PSNC executive in relation to the pandemic.

The PSNC has a number of sub-committees with responsibilities which range from supporting the negotiation process or managing external communications, to managing internal finances and staff structures. There is no human resources department. All decision making is done by the 31 member PSNC committee.

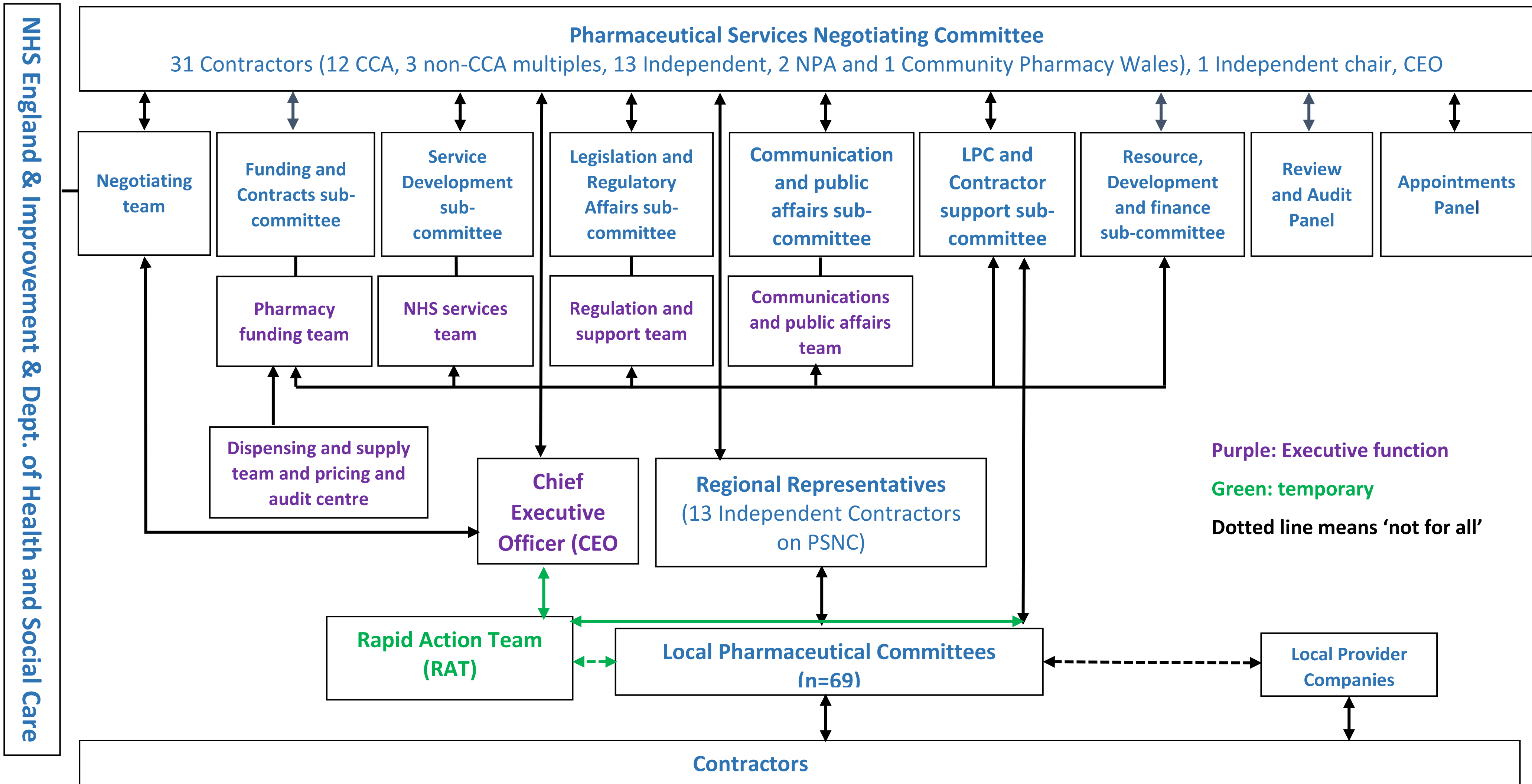
The CEO is currently supporting the PSNC committee; he is largely the voice of the PSNC with respect to communications and is an integral member of the negotiating team. While there is a small Admin Team, he has no Secretariat or central support executive team and therefore, similar to his senior team members, is constantly over-stretched.

To note from this diagram, is that neither the PSNC nor LPCs have external governance oversight. Consequently, there is no expectation for them to provide information to contractors regarding their activities or performance in a transparent manner. Whilst the LPCs have guidance on effective governance and forms for self-completion regarding internal governance, both the use of and adherence to these is optional.

Dotted lines are used to represent the fact that the relationship exists for only some LPCs.

Provider companies are set up to manage contracts with commissioners which involve a number of contractors. Whilst LPCs initiate, negotiate and set up new contracts as part of their representative role, they are constitutionally unable to manage service supply contracts. Without a management team to undertake this role on behalf of contractors this can be a barrier to service commissioning. In response to this, some LPCs have supported the set-up of local provider companies to assume this role. However, the nature of local contracts is such that they are not consistently present or may be insufficient in number to enable the support of a permanent local body.

Figure 5.1 Current PSNC and LPC structures

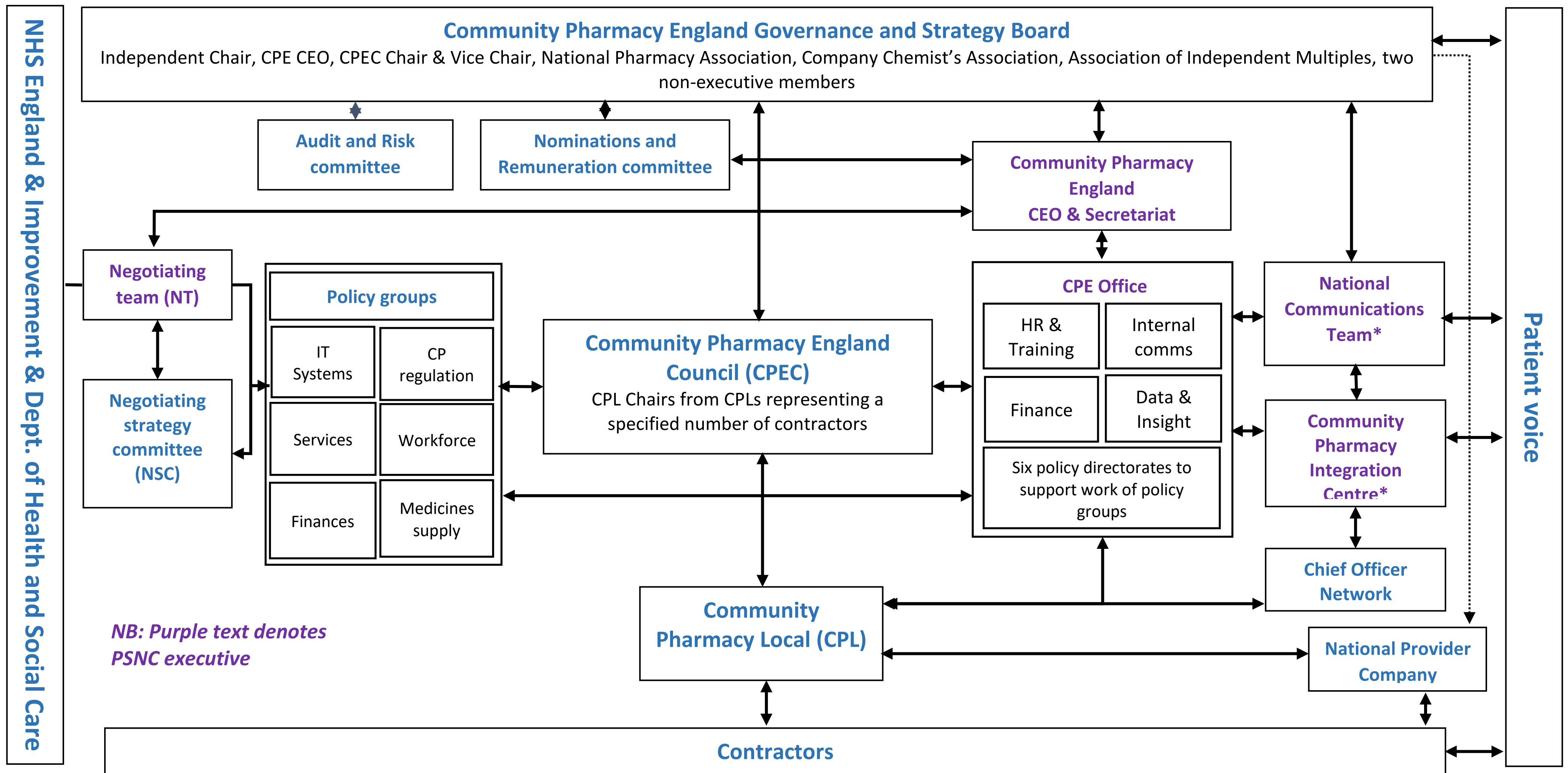


5.2 Proposed structure

An example of what the structure for CPE could potentially look like if all recommendations are enacted, is provided in Figure 5.2. Whilst this is purely to help the reader to visualise the proposals, the final structure would be decided upon by the CPEC and governance body once constituted.

To note the main differences of this proposal from the current structure are:

- Creation of an independent governance and oversight committee responsible for monitoring governance and performance within the CPE executive and CPLs on behalf of contractors (Top of diagram)
- Independent governance board constituted such that it can additionally assume responsibility for supporting strategy i.e. implementation of policies and approaches at a national level
- PSNC replaced with LPC chairs (CPEC) (Centre diagram), thereby providing more direct access for contractors to the negotiating team
- Creation of Policy Groups from the CPEC to consider all aspects of community pharmacy and agree policy in the best interests of all contractors (Left middle)
- Creation of a smaller Negotiation Strategy Committee (NSC) from the CPEC and policy groups to enable quicker and more responsive decision making (Left middle)
- Creation of a Negotiating Team who will work closely with the NSC but be employed as part of the PSNC executive (Left middle)
- Removal of the need for regional representative roles
- Creation of a secretariat to support the CEO and enable him to better focus on the negotiating team and process (Top middle right)
- LPC support services to improve efficiency and standardisation included
    - National Communications team, Community Pharmacy Integration Centre, Provider Company) (Right hand side)
    - Finance team to support LPC finance activities (Right hand side CPE office box)
    - Human Resources team to provide support with all appointment and employment processes and assume overall responsibility for training (Right hand side CPE Office box)
- Temporary Rapid Action Team consisting of a small number of Chief Officers replaced with a Chief Officer network consisting of all Chief Officers which can link directly with the PSNC executive team and support design, set up and delivery of all new services (Bottom right)
- The involvement of the Patient Voice in activities which can enhance effectiveness of the network and its operations
- The Audit and Risk Committee replaces the current Review and Audit Panel and would be responsible for monitoring CPE and CPLs adherence to the governance framework on behalf of the overarching Governance and Strategy Board (Top left)
- The Nominations and Remuneration Committee would be responsible for reviewing and recommending senior CPE and CPL appointments and benchmarking salaries for staff within the executive (Top middle left)



*These elements potentially jointly funded or supported by AIM, CCA, CPE, NHS England (PHIF), NPA, RPS, PDA

Figure 5.2 Possible structure for Community Pharmacy England (CPE) and its supporting bodies