

Independent Review of Community Pharmacy Contractor Representation and Support:

“Providing best value for contractors”

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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.

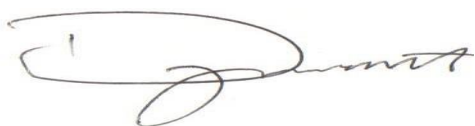
We also have to particularly thank the Pharmacy Review Steering Committee who have provided unwavering support and guidance to the team throughout the process. Their contribution has been central to ensuring that the project was delivered on time and that the report is presented to you in its current 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

A handwritten signature in dark ink, appearing to read 'David Wright', with a large, stylized initial 'D'.

David Wright

Table of Contents

Part One: Report Overview

1.	Executive Summary	6
2.	Recommendations	8
3.	Explanation for recommendations	10
4.	Recommendations, evidence, rationale and impact	22
5.	Current and possible proposed structure	34

Part Two: Main Report

Process

6.	Independent review team.....	39
7.	Review ethos & process	39
8.	Review agenda	40
9.	Pharmacy Review Steering Committee (PRSC)	41

Introduction

10.	Background information	42
11.	Local Pharmaceutical Committees.....	45
12.	The Pharmaceutical Services Negotiating Committee.....	47
13.	Summary of CCA, NPA, AIMp & RPS position statements	50

Method

14.	Project plan and summary of activities.....	52
15.	Summary of LPC interviews.....	56
16.	Summary of LPC and contractor focus groups.....	58
17.	National survey tool content	59

Results

18.	Contractor national survey results.....	60
19.	LPC national survey results	69
20.	Summary of PSNC Member interviews.....	78
21.	Summary of PSNC Senior Employee interviews.....	84
22.	Website review.....	85
23.	Other pharmacy representation models (Wales, Scotland)	89
24.	Other representation models (Medicine, Optometry)	92
25.	COVID-19 Addendum	96

Discussion

26.	Discussion & Conclusion.....	101
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Glossary of terms

28.	Glossary of terms and acronyms.....	120
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Appendices

29.	List of appendices (On-line only).....	121
30.	References.....	122

Part One: Report Overview

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 Gaggles 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 'piloting' 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)'	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Improved image for community pharmacy nationally Cost of rebranding for PSNC
(2) Rename all LPCs to "Community Pharmacy [locality] (CPL)".	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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'	<ul style="list-style-type: none"> Chemist is an outdated term which has no relevance to modern community pharmacy practice 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

	<ul style="list-style-type: none"> • To develop one vision and voice for community pharmacy in England • To support activities across CPE • To support response to contract changes 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Continuous and ongoing improvement for system
(7) Limit membership for all committees to 12 years (three terms of four years)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Repeated calls for better presentation of community pharmacy in the media to strengthen negotiating position both locally and nationally 	<ul style="list-style-type: none"> • To improve community pharmacy representation in the media and raise the role in national consciousness

	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Clear gap between LPCs and PSNC and national decision making • Clear gap between contractors and PSNC 	<ul style="list-style-type: none"> • CPLs central to management and delivery of CPE

<p>agreed minimum number of contractors.</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.
<p>(14) Create negotiation policy development groups from CPEC designed to consider all aspects of community pharmacy within the negotiation process</p>	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> Centralised CPL and CPE support bodies will require additional funding 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Greater security for CPE Reduced risk for contractors with respect to the national contract negotiation
(21) To create a CPE transformation and development fund	<ul style="list-style-type: none"> Significant initial costs associated with the three-year transformation plan recommended here No additional capacity within PSNC executive to deliver this 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> The NHS holds funds to support transformation processes The Pharmacy Integration Fund was set up to support better integration of pharmacy into the NHS 	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> More efficient CPLs Resources freed up to enable better national support for CPLs and more effective negotiations

	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • No evidence to support committee sizes larger than 10 • The committee is a significant LPC cost • Proportionality can be maintained with 10 members 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Improved CPL (and CPE) efficiency • Better value for money for contractors
(26) Identify and implement effective approaches to engaging with local contractors.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Greater satisfaction reported by contractors • Better informed negotiation policy development
(27) Provide honoraria for all members of CPL committee to compensate for	<ul style="list-style-type: none"> • CPL Chair role is pivotal to governance of CPL and should not rely on individual good will 	<ul style="list-style-type: none"> • Additional cost to CPLs

time taken to deliver roles effectively and improve engagement	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Evidence that appointment and employment practices within LPCs currently vary • National templates for employee roles are available but use is optional 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • More harmonious and effective CPLs
(32) Focus levy funded activities on representative rather than support related activities	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.

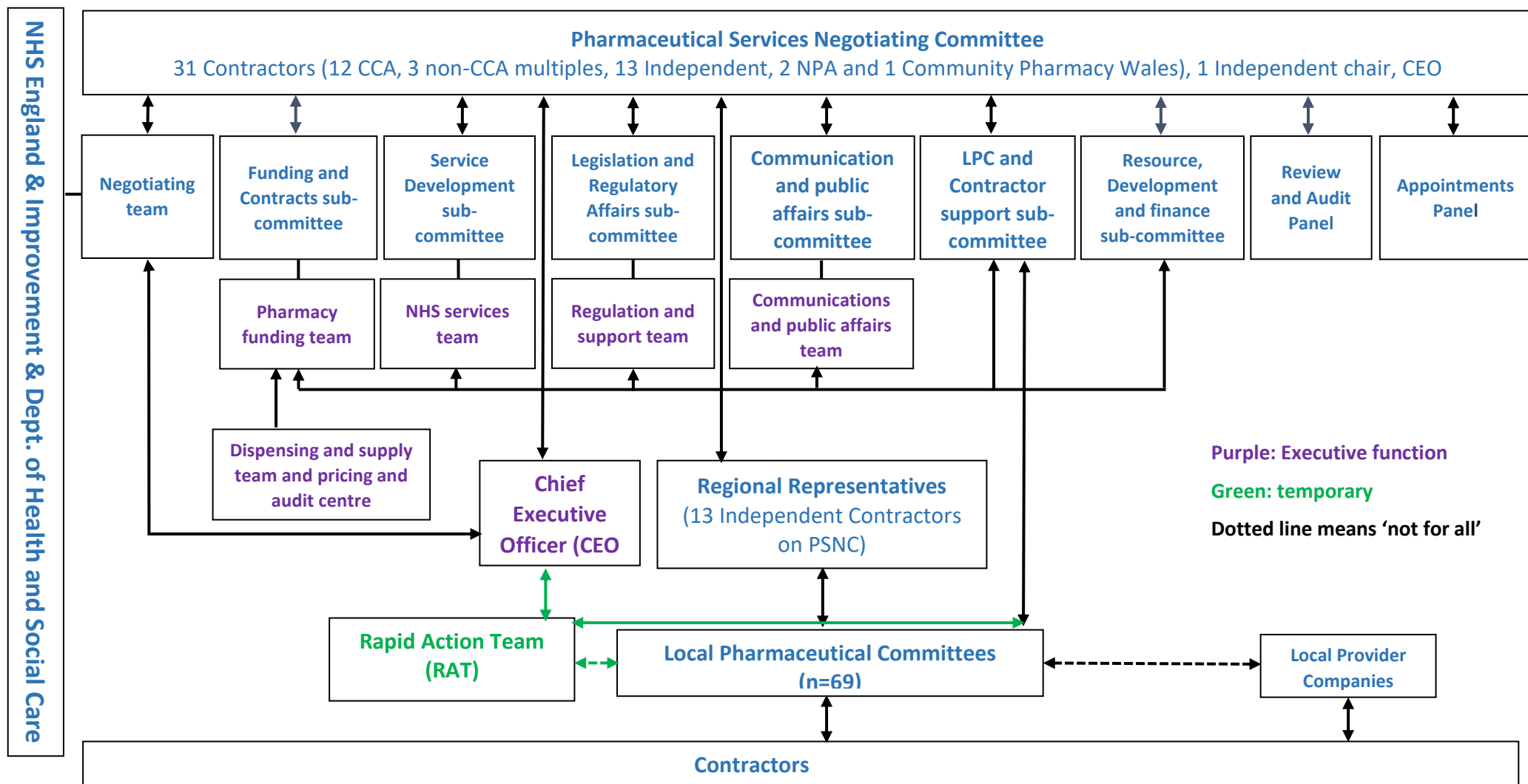
The CEO is currently supporting the PSNC committee; he is largely the voice of the PSNC with respect to communications and is an integral member of the negotiating team. While there is a small Admin Team, he has no Secretariat or central support executive team and therefore, similar to his senior team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

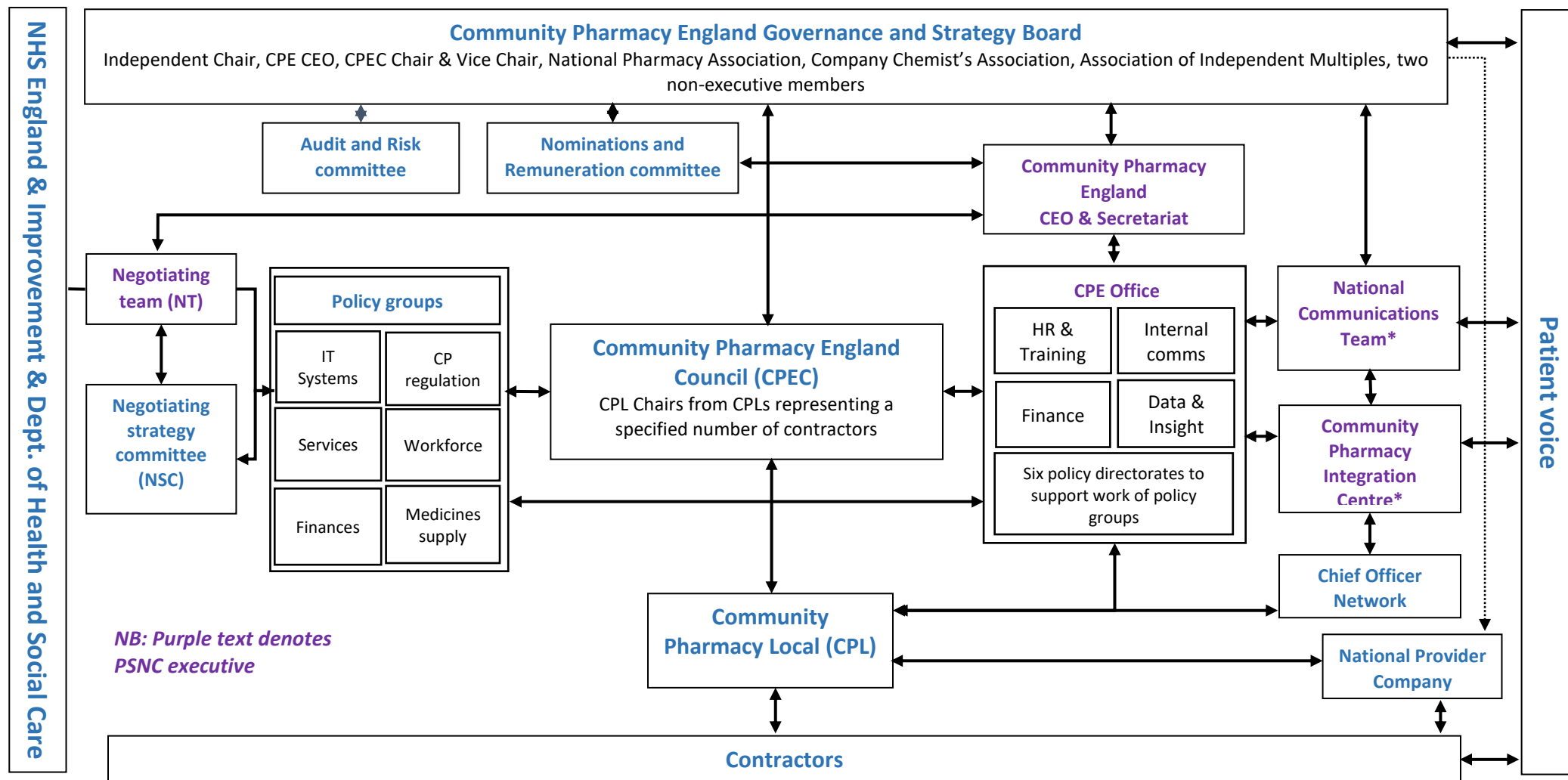


5.2 Proposed structure

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

Part Two: Main Report

Process

6. Independent review team

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7. Review ethos & process

The review has been undertaken with the following underpinning principles:

- Openness and transparency
- Provide everyone with the chance for their voice to be heard and considered
- Question the reasoning behind everything and where possible identifies the underpinning rationale
- Focus on evolution rather than revolution creating realistic timeframes for all recommendations
- Provide a rationale for all recommendations with underpinning evidence
- Expect new ideas to be carefully tested before widespread adoption to ensure that we achieve the desired outcomes and identify any unintended consequences
- Recommendations to be ideally delivered within the current funding envelope

The review consisted of all the following elements:

- Understand the historical and current context around the system under review
- Understand the factors influencing how the system operates
- Identify examples of good and poor practice
- Identify the elements of the system which require challenging and seek views on them to understand their rationale combined with system willingness/resistance to change

This information was then collated and used to identify what needed to change to ensure that the review agenda was delivered. The final recommendations result from this.

8. Review agenda

The independent review team's allocated agenda was:

'to ensure that contractors get the best value from the PSNC and LPC infrastructure'

The objectives set for the team were:

- What is working well in LPCs and PSNC and what could be improved?
- What representation and support is needed by contractors now – and what is the future requirement likely to be?
- What are the most effective structures for current and future demand?
- How should the representation and support for contractors be financed?
- What is the best structure to ensure all contractors are represented well?
- What, if any, changes are needed now and over the life of the new Contractual Framework and beyond?

Providing best value for contractors is, in itself, an undefined aim and consequently we have attempted to break this down.

'Best value' for contractors is obtained first and foremost through the negotiated contract i.e. we need to ensure that the infrastructure is optimised such that all future community pharmacy contracts are designed to deliver the following:

- A service which delivers a positive contribution to patient care
- A work environment which ensures patient safety and high-quality patient care
- A role which is satisfying and fulfilling for all members of the community pharmacy team
- A sufficient profit margin to make holding a community pharmacy contract worth the risk associated with it
- Delivery of services which align with the commissioner's agenda/needs

For contractors paying a monthly levy to their local pharmaceutical committee this should additionally include the following reassurances:

- Transparency with respect to how the levy is used and a regular forum is provided where this can be openly questioned
- The levy is used fairly and equitably for all contractors
- LPC performance is transparent to enable comparison with other LPCs
- There are opportunities to express contractor views in order to inform the national negotiating strategy and vision for community pharmacy
- The fees are used to enhance the national and local reputation of community pharmacy regarding the contribution that can be made to NHS and public health agendas
- Local services set up so they may lead to, and align with, the national contract
- Local health and social care decisions are made fully cognisant of what community pharmacy contractors can offer and impact on patient care
- There is a culture within LPCs of reflection and continuous improvement

9. Pharmacy Review Steering Committee (PRSC)

The project steering committee was convened to support the review process. Membership was designed to ensure equal provider and purchaser representation plus input from a similar committee with experience of undergoing a recent review process.

Members and affiliations for the purpose of the review are provided below:

Chair

David Wright	Professor of Pharmacy Practice, University of East Anglia
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Purchasers

Asif Alidina	Independent contractor representative (Self-nominated, selected)
Reena Barai	Independent contractor representative (Self-nominated, selected)
Peter Cattee	AIMp representative (Nominated)
Mark Ireland	CCA representative (Nominated)
Adrian Price	CCA representative (Nominated)

Providers

Simon Dukes	CEO Pharmaceutical Services Negotiating Committee (Nominated)
Ruth Buchan	CEO Community Pharmacy West Yorkshire (Self-nominated, selected)
David Bearman	LPC Member South West (Self-nominated, selected)
Vicki Roberts	LPC Member West Midlands (Self-nominated, selected)
Shilpa Shah	CEO Kent Local Pharmaceutical Committee (Self-nominated, selected)

Richard Whittington	Local Optical Council Support Unit (LOCSU) representative
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Observer

Zoe Long	Communications Director, PSNC
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Selection was based on expression of interest combined with a desire to ensure that the committee covered all geographies and was appropriately diverse.

Introduction

10. Background information

Community Pharmacy: A very brief history

Pre-NHS, Community Pharmacy was the first choice for patients requiring an initial diagnosis and treatment. This was because a visit to their General Practitioner (GP), who were all operating in a private capacity, would be expensive. The inception of the NHS in 1948, and in particular its provision of free access to GPs and medicines, transformed the role of the community pharmacy from the first port of call for all health-related problems to predominantly being a supplier of medicines. As the NHS became more successful, patients fully embraced the free access to doctors and the number of medicines supplied increased year on year, the community pharmacy's role was then largely redefined around this function.

The community pharmacist scientific expertise underpinned the supply role, with many medicines still requiring formulation within the dispensary until the early 1990s. The rapid expansion of the pharmaceutical industry from the 1960s eventually put paid to the need for extensive formulation expertise within community pharmacy with the medicines supply role becoming increasingly technical and deliverable through robotics and technology.

As a result of the transformation of the supply function, a number of attempts have been made to change the direction of community pharmacy since the 1980s, starting with the Nuffield report. Perhaps the most influential was the change to the community pharmacy contract in 2005, whereby a move from dispensing volume to service provision from community pharmacy was signalled by the Department of Health (1). Hereby community pharmacists were to be paid for delivery of medicines focussed services in addition to the traditional medicines supply function. The plan being, that over time, the funding balance would transfer to services from supply.

In attempting to force community pharmacies to centralise the dispensing function and become more efficient within this element of its role, the government chose to significantly cut the community pharmacy contract in 2016 by £200m per year. Over ten years this is believed to equate to a 25% funding cut overall.

Whilst some elements were planned for removal from the community pharmacy contract e.g. medicines use reviews and the pharmacy establishment scheme, a pharmacy quality scheme was introduced. This was designed to reward community pharmacies for improving medicines safety, integrating into the primary care team and promoting healthy living.

The change to the community pharmacy contract and funding cut has resulted in:

- Community pharmacy closures (2, 3)
- Concerns regarding reductions in staffing levels (4)
- Low community pharmacy staff morale (5)

Recognising the government's desire for centralised and automated medicines supply in primary care, a number of distance selling pharmacies (DSPs) have since entered the market, with some success in taking a proportion of the dispensing volume. Although such models are yet to be seen to be profitable.

In 2019 the Pharmaceutical Services Negotiating Committee (PSNC) negotiated a five-year contract for community pharmacy with an in-built annual review process. This was a significant departure from previous 'yearly' contracts, as it was designed to provide stability within the sector and to enable business owners an opportunity to plan for the future and realise efficiencies through an increase in the use of technology. The five-year flat funding agreement, however, also represents a further significant reduction in income in real terms over the period of time as the cost of inflation was not included (6). The recent changes to the pharmacy contract are additionally against a backdrop of lower retail footfall, increased business rates, basic minimum wage rate rises, introduction of the Falsified Medicines Directive, Brexit and a weak pound (7).

This coalescence of factors affecting community pharmacy and its future viability, is the platform on which this review is being undertaken. It has therefore never been more imperative that future contract negotiations are optimised to ensure that the future of community pharmacy is protected. Furthermore, with no discernible increase in national funding over the next four years then without greater efficiencies and cost-cutting within the sector, alternative income sources will need to be sought and effective local pharmaceutical committees, which identify and optimise all opportunities, will be central to this agenda.

In 2020, community pharmacy is again reinventing itself as a centre for health promotion and where everyone is directed to it, for initial diagnosis and treatment. Due to significant shortages within general practice, community pharmacy-based services are now being developed by NHS E&I in co-operation with a number of local pharmaceutical committees across England to reduce GP workload and increase patient access to care.

Consequently, the community pharmacist role has, in many respects, gone full circle. Not because a visit to the GP would be expensive but because they are just too difficult to access and all alternative routes need to be used by patients where appropriate in the first instance. A lack of GPs, combined with a plethora of prescribing and public health challenges in primary care, means that there has never been a better time for community pharmacy to negotiate its future.

The National Health Service

Since 1948 the one constant within the NHS has been change. Central, regional and local management structures have almost constantly been in flux with each change of government regularly resulting in a new plan or strategy. Consequently, regional and geographical footprints constantly change as do the national and local commissioning arrangements. Against this backdrop community pharmacy has to negotiate its future both at national and local levels.

In 2020 the NHS has seven regions, up from four in 2019, 44 Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICS) (the former slowly transforming into the latter) (8), and approximately 1,200 Primary Care Networks (PCNs) intended to serve populations between 30 and 50,000 (9). Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) have traditionally been one of two main purchasers of local community pharmacy services (there were 191 CCGs as of April 2019 (10)). CCGs are currently merging to more closely align with STPs and ICS footprints. The other main commissioner and local authorities are already being aligned.

The role of STPs was to develop partnership working between NHS and care leaders for the purpose of improving care for their local population. ICS are an agreement by local leaders to work more closely together and jointly manage resources. Objectives for STPs and ICS include better prevention of illness and admissions to hospital.

Primary Care Networks (PCNs) have been introduced to improve primary care health provision at a more local level with plans to have one clinical pharmacist in each by 2020 and five (one per medical practice) by 2022 (11). They are to be delivered through a Direct Enhanced Service contract (DES) which set out targets and associated remuneration. In addition to provision of funding for additional staff, to support the diminishing GP workforce, PCNs will be given targets to deliver and will receive additional funding once achieved. Central to this is the provision of structured medication reviews and optimisation, enhanced health in care homes, personalised care, anticipatory care, earlier diagnosis of cancer, cardiovascular disease identification and prevention and reducing health inequalities.

Although other primary care healthcare professionals are to be included within PCNs, pharmacists will be at the centre and consequently this creates both an opportunity and challenge for community pharmacy. The opportunity is provided by having colleagues in medical practice with whom direct communication may be facilitated, the challenge being the potential loss of community pharmacy employees into these posts, thereby creating greater workforce challenges.

When considering the targets however it can be seen that community pharmacy could make a significant contribution to all of them. To encourage community pharmacy involvement in PCNs, the Pharmacy Quality Scheme in 2019, included a requirement for contractors within a PCN to identify a community pharmacy lead and to provide evidence of their engagement. This process was to be facilitated by the Local Pharmaceutical Committee but the identification of the lead decided by the contractors themselves.(12)

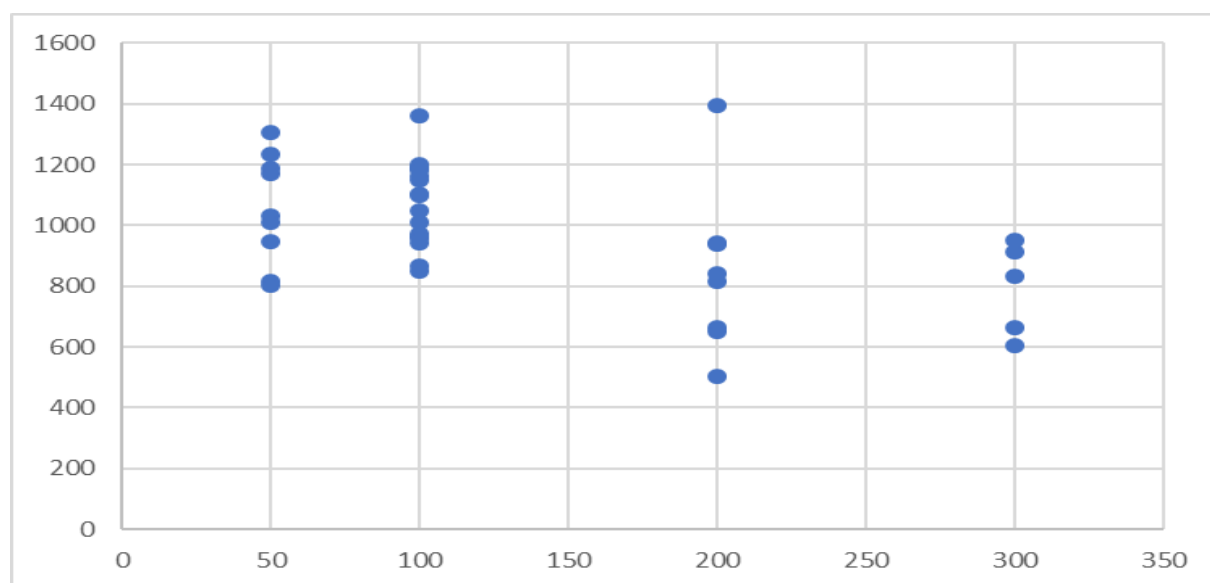
11. Local Pharmaceutical Committees

Local Pharmaceutical Committees (LPCs) were first constituted when the NHS was set up and the majority of contractors were small independent owners with only one multiple, Boots the Chemist. They were set up to ensure that contractors had a unified local voice within the health system and had access to local advice and support with respect to delivery of their NHS contractual requirements. This was at a time when the contract was exclusively focussed on prescription volume.

Funding

LPCs are funded through a levy which is automatically taken from contractors by the NHS Business Services Authority on a monthly basis, with the amount, based on NHS income, agreed on a yearly basis by the LPC. The average fee for contractors range from £500 per year to £1,400 with the number of contractors represented by an LPC ranges from 50 to 600. Income to LPCs therefore ranges from just over £65,000 to almost £600,000. With one outlier it seems that an LPC size of greater than 200 contractors, is more likely to result in a smaller levy, although a number of smaller LPCs are requesting a levy of less than £1000 per contractor (Figure 1). Total income to LPCs is £11.3M per year.

Figure 8.1 September 2019 Contractor levy vs LPC Size (50-99, 100-199, 200-299, 300+)



The main fixed costs associated with the delivery of LPCs are expected to be: employed staff salaries and the committee meetings themselves, needing meeting space, catering and backfill payments made for members where appropriate.

A model job specification for the LPC Chief (Executive) Officer is also provided by the PSNC (Appendix i). This reinforces the point that the CO is accountable to the LPC chair and responsible to the committee. The breadth of expertise and responsibility within the CO role however is such that the salary would be anticipated to be at a senior management level and this is a significant investment.

The most recent recommended LPC constitution (2014) is provided in Appendix ii. As autonomous entities there is no formal requirement to adhere to the recommendations.

In summary the **Model Constitution** states the following:

The LPC will:

- Consist of elected contractors each with a term of service of 4 years
- Be proportionally representative of the local contractor population with respect to Company Chemist Association (CCA) membership, Association of Independent Multiple pharmacies (AIMp) membership and independent contractors.
 - CCA and AIMp members will be nominated to the committee, whereas independent contractors will be elected
- From within the committee a chair, vice chair and finance officer will be elected
- The chair may receive an honorarium for their contribution to the LPC
- Employ a Chief Officer who will deliver the responsibilities of the LPC, being directly answerable to the chair, vice chair and LPC

Representation:

- Receive/respond to consultations by the local NHS commissioning board and Health and Well-Being board on behalf of the pharmacy contractors in the area for which the Committee is formed
- Respond to local and national requests for representation from LPCs
- Represent the views of the contractors to the regional PSNC representatives

Support

- Ensure transparency and equality of information and opportunity for all pharmacy contractors
- Advise any pharmacy contractor who needs help or assistance on NHS matters.
- Provide support to pharmacy contractors for local commissioning bids
- Be able to support the set-up of a provider company if deemed locally necessary
- Consider complaints by one contractor against another

Relationships

- Establish effective relationships with local commissioners and other relevant NHS bodies
- Respond to complaints made by other bodies regarding contractors
- Collaborate as appropriate with the PSNC regarding contractual matters

Governance

- Requirement to adhere to good governance practices set out by the PSNC (Appendix iii)
- Requirement to produce a yearly financial report
- Complaints regarding behaviour of LPC members to be handled within the LPC

Point to note from this:

- No maximum or minimum committee size recommended
- No maximum number of terms for committee members
- All problems and complaints are dealt with internally
- It is a model and adherence to governance requirements are optional

12. The Pharmaceutical Services Negotiating Committee

The history of the PSNC is somewhat more convoluted than that of LPCs. Originally, the negotiating body for community pharmacy was the then main representative organisation for contractor pharmacists the National Pharmacy Union. In 1947 the National Health Insurance Committee was formed and the NPU secured a place upon it. This was subsequently renamed the PSNC in 1976 and it was recognised by the Secretary of State for Health and Social Security as representative of British chemists [Community Pharmacies] for negotiations with the National Health Service. Since that time the constitution of the PSNC has adapted to try and maintain a balance between contractors, the developing numbers of practice and the widening range of providers and business models.

Although the numbers of NHS regions have varied over the years, at the time of the last PSNC instigated restructure, 13 regional representatives were elected from the Local Pharmaceutical Committees as independent contractors covering 13 NHS regions to make up the National Negotiating Committee. The NPA was allocated an additional two places on the committee. Consequently 15 places for multiples were added to ensure that the PSNC had equal representation between independent contractors and multiple owners. Based on the number of contractors represented, 12 places were allocated the CCA and 3 to non-CCA multiples. All members have to agree to abide by a Code of Conduct based on the Nolan Principles and be registered pharmacists. Independent representatives must be contractors. CCA and non-CCA multiple members are described as contractor representatives. There is also one representative from Community Pharmacy Wales (CPW). At present most of the English national pharmacy contract negotiated by PSNC is adopted by the Welsh Assembly Government, but where Welsh contractual arrangements differ from those in England, CPW negotiates on behalf of its contractors.

Regional representation and the link between LPCs and the PSNC is undertaken by the 13 regional representatives who all represent independent contractors (Appendix iv). The PSNC holds two meetings per year where there is a PSNC open forum at which LPCs can interact directly with them.

Structure / operations

The PSNC has a Chief Executive Officer who is responsible for the delivery of all PSNC actions and activities. The Chair of the PSNC is an external appointment for a term of three years and may only remain for two terms. The vice chair of the PSNC is appointed from within the membership for two years and also may only remain for two terms.

PSNC has six sub-committees and three other main groups. Members are elected and/or appointed on a biennial basis usually in May. Of the six chairs of the subcommittees, three are currently from multiple and three from non-multiple contractors.

Funding and Contract sub-committee has 10 members, including the Chair and is convened such that 50% of members are from multiples and 50% from non-multiple contractors. Its main function is to monitor the implementation of the funding elements of the Community Pharmacy Contractual Framework and explore the financial impact of new initiatives and funding models.

Resource, Development and Finance sub-committee, which largely considers the finances and resources within the PSNC is constituted from the five other subcommittee chairs, and

the Chair of PSNC. Its chair is elected from the full PSNC membership in order to reflect sectoral balance between multiple and non-multiple contractors.

Service Development sub-committee has six members including the chair (again divided evenly between multiple and non-multiples). Its functions include the monitoring of services, development of proposals for new services and Information Technology

LPC and Contractor Support sub-committee has eight members including the chair (divided evenly between multiple and non-multiples). Its functions include ensuring that PSNC provides appropriate support for contractors and Local Pharmaceutical Committees including training and conferences, and monitoring LPC and contractor satisfaction with PSNC's services.

Legislation and Regulatory Affairs sub-committee has five members including the chair. It's remit includes considering the legal and NHS policy issues and developments relevant to NHS pharmacy services. It also monitors and advises on data protection and regulatory issues.

Communications and Public Affairs sub-committee has eight members including the chair (divided evenly between multiple and non-multiples). Its main function is to monitor communications surrounding the Community Pharmacy Contractual Framework, including policy asks, position statements, collaborative working with other pharmacy bodies, parliamentary work and wider public affairs

In addition to the six sub-committees there are three other main groups.

- Negotiating Team
- Review and Audit panel
- Appointments panel

Negotiating Team has membership of the chairs of the Funding and Contract and Services Development subcommittees and four other members of PSNC to achieve the 50:50 balance of multiple and non-multiple contractors. It is chaired by the CEO of PSNC and in attendance are the PSNC Directors of Pharmacy Funding, NHS Services, Operations and Support and Communications and public Affairs.

The role of the Negotiating Team is to represent the views and interests of the Committee and the contractors who PSNC serves in agreeing the detail of negotiations with NHSE&I and DHSC.

Review and Audit Panel has five elected members who are not the PSNC Vice Chair or a subcommittee chair. The remit is to review the work of PSNC and its operational structures at specific intervals to assure efficient pursuit of PSNC's strategic and internal objectives. It is also the group that reviews and investigates complaints against the actions of PSNC, its staff and members.

Appointments Panel is comprised of six sub-committee chairs and two elected PSNC members. It is chaired by the Chair or Vice Chair of the PSNC and its purpose is to oversee the search for, and propose, a candidate for appointment as CEO and/or Chair of PSNC as appropriate.

Each year the PSNC organises two conferences for LPC representatives: a meeting with two representatives from each LPC (traditionally the Chief Officers and Chairs) and an annual conference with the numbers of representatives allowed to be sent, based on the number of contractors represented by that LPC.

Funding

The PSNC is funded by a levy from contractors funnelled through LPCs. From the total levy taken from contractors, PSNC takes between 20-35% and the LPC takes 65-80%. Total income to PSNC is £3.4M, leaving LPCs with a net income of £7.9M.

Constitution

The PSNC's remit, outlined in their constitution (Appendix vi), on behalf of community pharmacy contractors (referred to as Chemists in all documentation) consists of:

- Securing the best national contractual terms and remuneration
- Represent, serve and protect their interests
- Develop community pharmacy services for their benefit
- To consider and respond to legislative changes in connection with delivery of NHS services
- To check and agree the prescription pricing process
- Provide advice on NHS matters
- Support local negotiations surrounding new services

Terms of service for elected members are for four years.

Points to note from this:

- There is no maximum number of terms for PSNC members
- The primary method of linking PSNC to LPCs is through 13 independent contractors.
- There are no terms of reference for regional representatives
- The committees and groups underpinning the PSNC undertake a variety of roles with respect to policy development, delivery support and internal management.
- The balance of multiple to non-multiple contractors on both the PSNC and funding and contract sub-committee is 50/50 which does not reflect the balance nationally i.e. 60/40 in favour of multiple contractors.

13. Summary of CCA, NPA, AIMp & RPS position statements

Position statements regarding the review were released by the NPA, AIMp, CCA & RPS. The CCA position statement was released before the focus groups took place and was used by CCA members at all stage of the process to inform their responses (Appendix vii). The NPA position statement (Appendix viii) was released after the focus groups had taken place but before the national surveys were released for completion. We received the AIMp position statement later in the process (Appendix ix), with the RPS position statement released after the surveys were closed (Appendix x). A summary of the main points is provided here.

Company Chemist's Association (CCA)

1. Increase staffing levels at PSNC to enable them to better respond to the increasing demand both from government and LPCs
2. PSNC committee balance to be proportional with number of CCA/AIMp/Independent contracts
3. Focus on PSNC advocacy function to ensure they have the oversight, structure, processes and capabilities to deliver [the national contract] to a high level
4. Establish clear KPIs and lines of accountability for the PSNC
5. Review the LPC model constitution to reduce the variation in support to contractors which is current experienced
6. Creation of a set of principles to be used before LPCs choose to spend contractor money
7. LPCs should not be using Levy money to support compliance with CPCF
8. Reduce current number of 69 LPCs to 38 regional LPCs which would be responsible for 300 contractors and would release funding
9. Reduce local pharmaceutical committee size to release further funds
10. Set up a national provider company

National Pharmacy Association (NPA)

1. Increase the capacity for local service development & implementation
2. Streamline the network of LPCs, to better align with NHS structures and release funding
3. Reform the PSNC mandate to focus on national negotiation
4. PSNC balance to remain equal between independents and multiples
5. Invest in local Leadership development program to include PCN pharmacy leads
6. Define what good looks like and LPCs provide yearly statement regarding expenditure and value provided
7. Ensure governance serves all i.e. both independents and multiples
8. Add in a regional layer to reduce local duplication
9. Pilot any changes
10. Consider new ways to support service development and innovation e.g. Set up a national Pharmacy Service Development Unit

Association of Independent Multiples (AIMp)

1. Reduce duplication and improve consistency of provision across LPCs
2. Introduce key performance indicators for LPCs
3. Reduce the number of LPCs to 45
4. Invest some of the savings realised from streamlining into local initiatives and working with PCNs

5. Use some of the saving to fund the PSNC to enable it to provide better central support to contractors
6. Review purpose of PSNC to focus on negotiations and working closely with LPCs
7. Recognise the importance of the local network

Royal Pharmaceutical Society (RPS)

1. Recognise that much innovation is driven locally
2. PSNC to continue to enhance content in the national contract
3. Pharmacy integration fund sought to be used to develop local initiatives which encourage integration e.g. PCN and community pharmacists to work together on the Enhanced Health in Care Homes service specification
4. Reduce current variability in LPC practice across the country through sharing best practice
5. LPCs to be more supportive of those assuming responsibility for lead PCN community pharmacist
6. LPC focus on developing local leaders
7. LPCs provide advice on the financial consequences of taking on a service
8. To deliver business development, innovation and quality assurance LPCs may need a regional structure for support
9. LPCs to become more representational and include members beyond contractors
10. LPCs shift from representational role to project management role

Similarities

CCA, AIMp and NPA recommend:

- streamlining of the LPCs to release funds
- introduction of better governance / accountability structures
- focus PSNC on negotiating function

Whilst RPS recognises the variability in LPC delivery it recommends that this is addressed through sharing of best practice rather than the introduction of any governance / accountability into the system.

RPS and AIMp both recognise the value of the local networks.

Differences

- CCA would like to see released funds used more centrally, NPA would prefer them to be used to increase local service commissioning and delivery, AIMp for both.
- CCA prefer proportional representation on the PSNC whereas NPA would like to keep status quo.
- RPS is largely focussed on recognising the importance of LPCs but wants them more focussed on new service initiatives and implementation than they currently are.
- RPS believes that the LPCs can be used to develop local community pharmacy leaders.

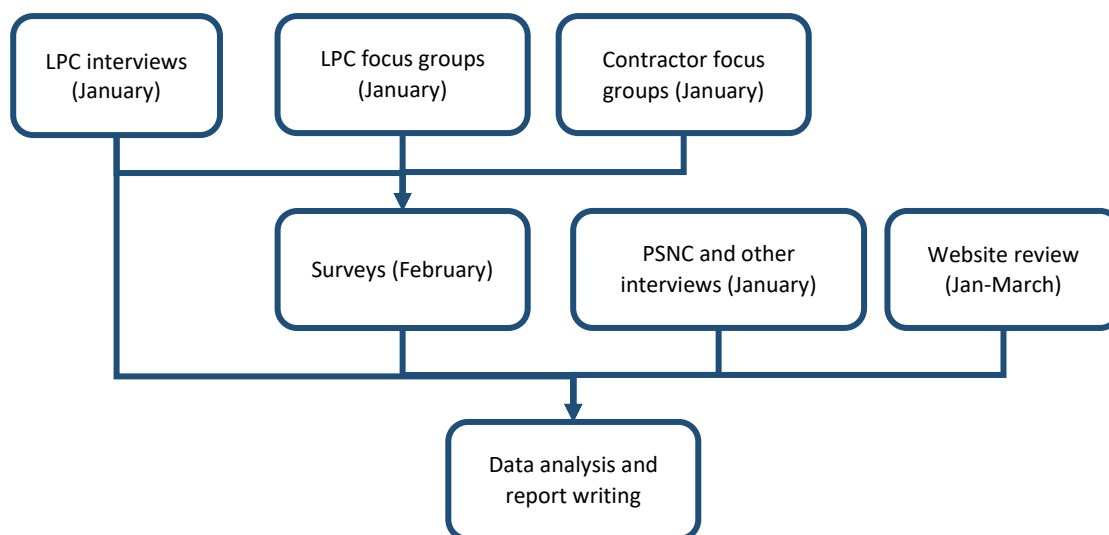
AIMp also commented on the review process itself, requesting that it should be a fair and transparent process.

Method

14. Project plan and summary of activities

A flow diagram of the method used for this review is illustrated in figure 11.1 below.

Figure 11.1: Flow diagram of the review process



Survey design

1. LPC Interviews

Interviews were conducted throughout January with a small number of LPC Chairs and Chief Officers from across the country to a) inform the development of the national surveys and b) inform the final report. These interviews were conducted by DW and lasted up to one hour. Notes were taken during the discussion.

2. LPC and contractor focus groups

The purpose of the focus groups was to inform the generation of the national survey. The review team needed a deeper understanding of the issues affecting LPCs and PSNC before designing the survey instrument. The focus group data was not used to formulate recommendations. A copy of the topic guide for the LPC and contractor focus groups can be found in Appendix xi. The aim was to conduct eight focus groups each with 8-10 participants. These were conducted in January 2020 by all members of the review team.

3. Survey design and development

Each focus group was attended by two facilitators so that detailed notes could be taken alongside the discussion. Upon completion of the data collection, MT, HF and LB independently collated their thoughts from the focus groups by reading the discussion notes and, if necessary, listening to the recordings again. DW collated his thoughts from the interviews. A discussion was then held to establish the commonality and differences in the

topics identified from the data. This approach to analysis enabled the review team to develop their own understanding of the data to ensure that different perspectives were taken into account during the development of the surveys.

After the initial generation of the survey, multiple iterations were developed to refine and focus the questions. The review team tried to strike a balance between closed and open questions enabling us to report both breadth and depth to responses in the results section. These surveys can be found in Appendix xii (LPC) and Appendix xiii (contractor) for reference.

Data collection

1. Survey implementation

Two surveys were designed and distributed: one for each LPC to complete (69 responses expected) and one for contractors. A separate, shorter survey was developed that contained a smaller number of questions so that contractors with pharmacies in different LPCs could provide their views on each one independently. The surveys were released electronically on 28th January and closed on 29th February.

2. Website review

Each website was reviewed in turn. Where website links were not working, a google search for an alternative web-address was conducted. When annual reports and accounts were not found, a google search for an alternative place (e.g. PSNC website) was conducted to see if the annual reports and accounts were uploaded elsewhere. If an LPC website had restricted access to some parts of its website, access was not requested to these, only publicly available information was reviewed. We were asked during the review to include the date an LPC website was last updated. This information was not routinely provided on LPC websites, so google was used to aid this, through typing “inurl:” followed by the LPC website address into a google search. This then listed the pages on the website, and the date last updated which could then be filtered to show the most recently updated page (this does not include information from PSNC feeds on PSNC hosted LPC websites which appear to update automatically, similarly it does not include updates from social media feeds on these websites which may be more contemporaneous than other information on the website).

Other information gathered was:

- If the LPC link was active and working
- If the number of pharmacies represented is reported on the website
- If the 2018-19 Annual Report had been published (and if no report for 2018-19 the last date an annual report was published)
- Governance documents and the last time they completed a governance self-evaluation
- Strategy for the LPC and if it was current
- Calendar of events and activities and if it had upcoming events/meetings listed
- Social media feed on the website (it was noted if it was inactive for a period of time)
- Training opportunities listed – including face to face and online (specifically provided by LPC and not those provided by CPPE or other providers)
- Information about PCNs (if this was just links to PSNC resources this was noted) and PCN leads

- Resources on the new 5-year pharmacy contract (and if this was just links to PSNC resources this was noted)
- Information about PQS
- Resources for advanced services (and if this was just links to PSNC resources this was noted)
- Resources for locally commissioned services (and if the information / service specifications were out of date this was noted)
- Whether they were part of a collaboration / were working with other LPCs in the area
- Excerpts from annual reports on the activities they undertook for 2018-19 (this is not exhaustive, just a snapshot)
- If the contractor levy was stated on the website and if this was broken down for annual and monthly costs to contractors
- End of year accounts, if they were reported, and they were summarised in terms of income from levy and other sources.
- Total spending reported, if underspend / reserves spent, total value of LPC reserves, staff costs, costs for LPC meetings (including locum fees and honorariums), training & contractor events, office rent & rates, office and administration costs (excluding staff costs), tax, bank charges & accountancy costs (and other related costs), PSNC levy, LPC collaborative costs and/or provider company costs & pharmacy support costs.

3. PSNC member interviews

DW and MT undertook one-hour telephone interviews with each member of the PSNC Committee during February and March 2020. Interviews focussed on what they believed should result from the review, their views on the Committee, the Negotiating Team, PSNC employees and LPCs generally. Notes were taken during the discussion. The results of these interviews informed the overall recommendations of the report.

4. PSNC employee interviews

DW interviewed five senior PSNC employees during February 2020 to better understand their roles, what they believe they did well and could do better and to identify what they would ideally like to see result from this review.

5. Interviews with other relevant organisations

Relevant professionals from the following organisations were interviewed by DW during January, February and March:

- Community Pharmacy Scotland
- Community Pharmacy Wales
- General Practitioner Committee within the British Medical Association

These interviews were undertaken to understand how their organisations operated or their perspective on the review.

6. Position statements

During the process of the review position statements on the review were published by the AIMp, CCA, NPA & RPS. These were summarised, with consensus and disagreement identified.

Data analysis and development of recommendations

1. Surveys

HF and LB analysed the contractor survey qualitative responses. Responses to the open-ended questions were summarised by one member of the review team and then confirmed as appropriate by another. DW undertook the quantitative analysis.

MT and LB analysed the LPC survey qualitative responses. Responses to the open-ended questions were summarised by one member of the review team and then confirmed as appropriate by another. DW and MT undertook the quantitative analysis.

2. Website analysis

Data from the website analysis was presented descriptively. Those elements expected within the LPC governance framework were separated from those which were provided at the discretion of the LPC.

3. Interviews

Common themes within PSNC member and employee interviews were identified by DW and summarised and confirmed by MT. Individual recommendations were additionally identified and reported.

All other interviews were summarised to enable readers to identify the main learning points for the purpose of this review.

Data synthesis & report production

Both DW and MT discussed the output from the PSNC, LPC and other interviews repeatedly to formulate their ideas in relation to the common themes.

Once all data had been analysed and reviewed by each person independently, the review team met virtually over the course of a full day (due to COVID-19) to discuss the recommendations that should go into the report and the supporting evidence for each one.

The report was written by DW with input from all other members of the review team. The final report and recommendations went through a process of iterations within the team prior to finalisation.

15. Summary of LPC interviews

Seven chairs and eleven Chief Officers/LPC secretaries were interviewed to inform the survey design, identify good practices and obtain general views to inform the review.

LPCs consensus

- Importance of, and need for, LPCs
- Importance of maintaining local relationships
- Concerns about variation in LPC delivery
- Concerns regarding lack of independent governance
- Role in setting up and delivery of local services
- Recognition that innovation in community pharmacy usually starts locally
- Recognition that LPCs would benefit from key performance indicators to enable contractors to compare performance
- Agreement that one size does not fit all with respect to number of contractors represented as different geographies create different challenges e.g. rural versus large cities
- Need additional funding to support introduction of national services e.g. Transfer of Care around Medicines (TCAM) service as beyond usual remit
- No HR function in LPCs
- Recognition that the Committee is the most expensive element within LPCs
- Concerns regarding CCA member engagement within LPCs
- General consensus that LPCs should align geographically with commissioning bodies e.g. CCGs
- Benefits of federating to enable resource sharing or merging to reduce costs
- Overly broad constitution would benefit with some clarity and definition
- Need for provider company when setting up contracts with commissioner or an appropriate approach to addressing this

LPCs non-consensus

- Whether training was a responsibility for LPCs
- What an appropriate LPC size (committee) should be, although trend downwards
- The number of contractors an LPC should ideally represent
- Responses to the problem of non-CCA member engagement from positive solutions to allowing the problem to continue
- Appropriateness of including non-contractors on the LPC
- Appropriateness of COs having a voting right on the LPC
- Whether provider companies should be local or national
- Names – some Community Pharmacy ‘Local geography’, some retain LPC title

LPC views of PSNC

- PSNC doesn’t understand what is happening at the coalface
- PSNC doesn’t effectively listen to LPCs
- Pathway to communicate local innovations up to NHS England unclear
- Some LPCs report being unaware of what is happening at national level
- Duplication of effort between PSNC and LPCs

- Need to bring LPCs and PSNC together (similar to the LMC/BMA model)
- PSNC recognised as being underfunded
- Need national service templates from PSNC
- PSNC conference is didactic in its nature – limited time for discussion, documents not provided in advance
- PSNC too London centric
- Regional network does not work, regions too large and do not fit with any current structures

General

- Recognition that additional funding is no longer going to come from dispensing and that community pharmacy needs to reposition itself to deliver what the NHS and Department of Health and Social Care require from it
- Optional governance frameworks are subjective
- Provider companies needed with a number requesting that this be set up nationally
- Better sharing of resources between PSNC and LPCs and less duplication
- Need for a code of conduct for all members

Examples of innovative and/or good practice

- Regular LPC Contractor Survey to obtain feedback on LPC performance and obtain views and opinions
- Federating three LPCs covering 550 contractors such that only one CO required
- Regular contract awareness events with contractors
- Regular contractor visits
- Attend CPPE events to enable engagement with contractors

Recommendations from interviewees

- Increase involvement of patient and public voice in the process
- Develop local services which integrate the pharmacist into NHS pathways as opposed to in addition to them
- Consider workforce development within plans and negotiations
- NHS.net e-mail account for LPC employees
- PSNC to support evaluations to raise standards
- Set up national HR support
- Set up national treasurer/finance support team
- Set up a more formal CO support network
- Set up a national provider company
- All LPCs to be named Community Pharmacy 'local geography'

16. Summary of LPC and contractor focus groups

We listened to 72 people from across England representing LPCs and contractors. Half of all LPCs were represented.

Four LPC and contractor focus groups were conducted in January 2020: Taunton (10th), London (13th), Leeds (15th) and Leicester (16th) with all discussions lasting 90 minutes.

Demographics of the LPC sample:

- 32 participants, 11 (34%) female
- Mean age: 50 years, range 32 – 70.
- 29 LPCs represented from across England

Demographics of the contractor sample:

- 40 participants, 18 (45%) female
- Mean age: 45 years, range 28 – 64.
- 18 (45%) representatives from independent contractors
- Good representation from contractors in terms of ethnicity
- Good geographical representation from contractors

Main findings

Topics identified as requiring exploring within surveys and review

- Transparency / accountability / governance for both PSNC and LPCs
- Equitability with respect to services provided by LPCs e.g. LPCs providing head office functions for contractors which are already provided by multiples.
- Funding model and how the money is shared out between PSNC/LPC.
- Why GPs seem to have greater negotiating power than community pharmacists
- Contractor voice, vote, influence in the process
- PSNC understanding of community pharmacy and implications of actions for contractors
- Breadth of negotiations by PSNC e.g. no negotiation around IT or things that would make a better deal for pharmacy e.g. released time for training.
- Common voice and strategy between different community pharmacy organisations.
- Coordination of communications between representative bodies particularly with respect to representation and negotiation.
- LPC boundaries and organisation internally, regionally and nationally
- LPC roles and boundaries for those
- Communication between LPCs and PSNC particularly with respect to contractor needs
- Need for vision and strategy at both local and national levels.
- Communication of PSNC strategy and plans to LPCs.
- Relationships between PSNC and LPCs considering trust and confidence
- Sharing of learning between LPCs and PSNC
- How and what to measure with respect to value and impact of work by PSNCs/LPCs for contractors
- Skillset requirements for those within LPCs and PSNC.

17. National survey tool content

The LPC and contractor survey tools were built by the independent review team based on the findings from the focus groups and LPC interviews.

The LPC survey tool (Appendix xii) consisted of questions regarding:

- The committee size, frequency of meeting, length of terms of service
- Views regarding committee size and lengths of terms of service
- Views on committee membership and recruitment of employees
- Views on number of contractors represented
- Training for LPC members
- Views on LPC roles and responsibilities now and in the future
- Communication with contractors
- LPC governance, key performance indicators and a code of conduct
- LPC finances
- PSNC leadership
- PSNC transparency and governance
- PSNC representativeness, support and value for money
- How should the review recommendations be considered for implementation

The contractor survey tool (Appendix xiii) consisted of two parts. The first for general feedback on the system and the second for feedback on the performance of the local LPC within which the contractor(s) was located.

Part 1 questions covered:

- Type of contractors and number of contracts represented
- Views on the current PSNC/LPC structure
- Views on PSNC leadership, governance, transparency and accountability
- Views on PSNC communication and overall effectiveness
- Views on LPC governance, transparency and accountability
- Views on LPC leadership and representation effectiveness
- Views on LPC communications
- Views regarding which roles and responsibilities are appropriate for LPCs
- Examples of good LPC practices
- Views regarding financing of LPCs and PSNC

Part 2 questions covered:

- Type of contractors and number of contracts represented
- Views on local LPC governance, transparency and accountability
- Views on local LPC leadership and representation effectiveness
- Views on local LPC communication effectiveness

Results

18. Contractor national survey results

The following section is a summary of the main findings from this element of the review. All data available from this survey is available in Appendix xiv.

Respondent demographics

Section 1 of the survey was completed by respondents who represented 6441 contracts. 14 AIMp members represented 399 contracts, 8 CCA members represented 4971 contracts and 428 independents representing 1071 contracts.

Section 1: Contractor views on PSNC and representation structure as a whole

Whilst some respondents were positive about the PSNC and LPCs, recognising the difficult environment within which they were operating the majority of respondents were not satisfied with current representation structure.

- Lack of accountability, parity and standardisation in LPCs
- Structure and funding of PSNC with a committee size of 31 too large
- National negotiator under resourced for role and to mitigate current contract risks
- No governance at PSNC
- PSNC receives £3.4M to negotiate a £2.6Bn contract and LPCs over £8m to negotiate less lucrative and significantly smaller local contracts
- Savings to be made at LPC level re-invested at PSNC to strengthen national negotiations,
- Mixed LPC/ PSNC working will be necessary at Regional Level to ensure successful innovations are properly evaluated and rolled out – so that best practice can spread quickly.
- Better media presence required to increase public awareness of community pharmacy (CP)
- Negotiations undertaken by an unelected body
- Lack of one voice between community pharmacy bodies weakened negotiating ability
- Lack of representation for on-line pharmacies
- PSNC did not fully understand the challenges faced by contractors
- Concerns that PSNC does not hear the voice of LPCs
- Concerns regarding transparency of PSNC decision making
- Could reduce number of LPCs but important to maintain local relationships
- Need to represent contractors effectively across STPs and ICSs
- LPCs could be better at informing PSNC of contractors' needs
- Contractors wanted the training and support currently provided by LPCs to continue
- Identified significant variation in LPC performance

Contractor views of the PSNC

The majority of respondents agreed that

- They knew what the PSNC did for them
- PSNC did not represent their voice effectively or understood their needs.

Respondents were split regarding whether PSNC had a clear vision for community pharmacy

While many appreciated the communication and resources provided by PSNC there was concern that PSNC did not fully understand the demands on contractors and they were unable to negotiate a contract which was financially robust.

There were concerns regarding poor negotiation skills and the unfair balance of power held by NHSE&I.

Many recognised that a vision for community pharmacy exists but it has not been well communicated.

Suggestions were made to recruit specialist negotiators, gain advantage in negotiations by understanding the value of pharmacies through LPC data and to recognise the mistrust at the coalface if any restructuring plans are suggested.

The majority of respondents stated that they:

- do not think PSNC provided value for money due to poor negotiation outcomes
- cannot hold the PSNC to account
- do not understand how PSNC make decisions
- do not believe PSNC governance to be clear or appropriate.

Recommendations

- PSNC should present its accounts and a proposed budget to the LPCs
- Contractors should be given the chance to vote for any contract negotiations before the PSNC agree to them
- Increase transparency through audit and observation of meetings

Many respondents described the communication (particularly emails and website) as comprehensive with respect to regulatory matters and contractual obligations and that it had improved greatly over the past decade.

It was noted that webinars and roadshows should be continued and increased, there should be more information on the negotiation processes, more consultation with contractors on decisions, and regular short alerts.

Independent contractors want the PSNC:

- communications to be more honest, clear and concise, specifically in regards to negotiation discussions (i.e. publish all dialogue with the DoH)
- to be more responsive (to queries) and two-way
- to implement more channels of communication including having more face-to-face links with PSNC and information sent via text message or WhatsApp.

Beyond sharing information and supporting contractors, there was a lack of clarity with respect to what the PSNC was believed to do well. There was recognition of the challenge of negotiating in current climate of funding cuts.

It was noted that recent management changes had started to improve PSNC culture.

There was recognition that additional resource was required for PSNC to enhance its effectiveness.

The majority of respondents stated that the national contract negotiation could be improved

There were calls for the PSNC to:

- focus solely on the negotiations
- improve their skills as negotiators
- expand the range of voices represented by the PSNC to include all community pharmacy representative bodies
- allow LPC and local contractor views to shape negotiations and discussions.

A frequent suggestion from contractors was that the PSNC should emulate the British Medical Association (BMA)/General Medical Committee (GMC) approach to negotiations as they were seen as successful.

There was a call for improved representation of what community pharmacy does and thereby improve public support for a better negotiated contract. The LPC knowledge and infrastructure would be pivotal to this.

Section 2: Contractor views of LPCs generally

Satisfaction

Satisfaction with LPCs was variable with independent and AIMp contractors more satisfied than CCA contractors.

Main concerns were regarding variation in performance, quality, experience, financial transparency and efficiency.

Preferential treatment of independent contractors over multiples was identified as a concern.

Those who were less positive they believed that their LPC operated completely independently of them and without listening to them.

Accountability and transparency

Similarly views on accountability, and transparency of LPCs was variable with CCA contractors the least positive.

There was recognition that until you have been an LPC member you don't understand the landscape within which they operate.

A small number of anecdotal accounts of malpractice within committees specifically relating to misuse of funds or commissioning were reported.

There was nearly even split regarding whether there should be a maximum number of terms of office across AIMp, CCA and Independents.

Limiting the number of terms was believed to result in a loss of experience and expertise and that members' term of office should be dependent on performance.

LPCs struggled to attract members and therefore limiting terms may weaken the structure.

It was also recognised that limiting the number of terms would ensure a ‘fresh’ approach and ideas, prevent cliques and personal agendas and therefore ensure transparent governance and complacency/stagnation:

Many respondents also stated that members should be democratically voted in.

Membership

The majority of respondents stated that non-contract holders should **not** be on LPCs (no financial risk, no real understanding of the business model of pharmacy and would ‘*dilute the focus of LPCs*’).

It was recognised that it could be useful to include non-contract holders with relevant expertise but on a limited non-voting and temporary basis.

Diversity

The majority of respondents agreed that the committee should reflect the diversity of the population it is representing.

It was proposed that engagement, encouragement and advertising (specifically through open communication) could help to ensure diversity.

Reasons for disagreeing included concerns regarding positive discrimination, tokenism or quotas.

LPC size and efficiency

Whilst there were variable views regarding the number of contractors represented by LPCs there was recognition that in the climate of the current contract the cost of LPCs should be reduced.

CCA respondents recommended that LPCs should represent 300 contractors to maximise efficiency.

Representing 200 contractors was also recommended but noting that the size of the geography had to be taken into account.

Independent respondents were concerned that if LPCs become too big then they will lose their local knowledge of contractors and commissioners, services would become impersonal and the quality of support would decrease.

It was noted that bigger LPCs might be better in terms of providing support and negotiating locally.

Alignment with emerging NHS structures e.g. STPs and ICSs was recommended as historical boundaries are no longer appropriate.

There was a feeling that if the number of contractors shrank then the number represented by LPCs would reflect this. Consequently, some LPCs would be forced to consolidate to survive.

Satisfaction

One sixth of respondents stated the LPC was already doing well with no need for change.

Satisfaction could be improved by

- Engaging more with contractors
- Better representing contractors' views
- Improving local communication
- LPCs should better hold the PSNC to account

Value for money

Less than 50% of respondents across the board believed that their levy represented good value for money with CCA members the least satisfied.

Those who stated the levy represented good value justified this decision based on the services they received such as support, training and commissioning local services.

Companies with contractors located within different LPCs stated that value for money was not linked to amount paid but due to variations in the effectiveness of different LPCs.

Number of contracts set up by LPCs was seen as a marker of effectiveness.

Contractors within one LPC stated that it was difficult to judge value for money when they could not compare the effectiveness of their LPCs with others.

It was noted that PSNC should be held to the same level of scrutiny with respect to the proportion of levy paid to them.

Measurement of LPC performance

The majority of responses focused on three ways to measure LPC performance: monitor activity through LPC reporting, benefit to contractors and benchmarking.

Monitoring activity would be measured through:

- Contractor engagement with the LPC
- Committee member attendance and activity
- Financial transparency
- Contractor satisfaction surveys

Benefit to contractors would be measured by:

- Income generated
- Income spend on general support
- Local commissioned services
- Income contractors derived from commissioned services.

This could be achieved by benchmarking against other LPCs and therefore key performance indicators (KPIs) were required.

Representation

The majority of independent or AIMp contractors agreed that the LPC meets their needs explaining that they felt listened to, received helpful information and that they negotiated appropriate local services.

A few comments reflected that the LPC was limited in what they could achieve because they were trying to offer too much, which might not be relevant to local contractor's needs

Concerns were raised regarding LPCs setting up poorly paid services i.e. those without an appropriate level of profit.

CCA disagreed that LPCs understood their needs stating that some communicated with pharmacies and not the CCA contractor.

It was noted that improving communication would reduce duplication of effort e.g. training and that the CCA would be open to LPCs providing the training rather than the companies.

Variation across LPCs was again reported here with respect to support.

LPC committee size and structure

Many respondents supported smaller committees recognising that size of committee was not related to effectiveness.

There was recognition that within large committees most of the discussion and activity was led by a smaller proportion.

Others noted that effectiveness should determine the size of the committee.

Communication

The majority of independent and AIMp respondents were satisfied with LPC communication with CCA members less so.

Newsletters and emails are well received and the monthly tracker helpful. Although frequency and size were noted as important considerations.

Some reported not receiving any communication from their LPCs or that it did not reach the right people.

Duplication of PSNC communications by LPCs was reported.

Communication could be improved by:

- LPC focussing on information which is local and specific
- Not replicating what PSNC send out
- Prioritising what is important and make this distinct from general information
- Highlight local opportunities/ communications from others
- Keep communication concise and relevant, avoiding editorial opinion
- Use social media like WhatsApp for updates, but keep newsletters by email
- Webinars
- Provision of monthly trackers
- More face to face contact in visits or contractors meeting
- Have right contact list i.e. ensure head office also gets emails not just NHS branch email addresses

LPC roles through levy funds

Strong support was reported for LPCs implementing local and national contracts and supporting contract changes.

There was significantly less support for LPCs using the levy for training purposes of any nature some stating that is was outside of their remit.

Independent contractors were more positive regarding levy funds being used for training than CCA and AIMp respondents.

It was noted that levy funds were not sufficient to pay for training and that is should be built into national negotiations when setting up new services.

It was also noted that there were nationally funded bodies who were responsible for community pharmacy training.

Webinars were recommended as this mode of training was preferred by some

Roles which were believed to be important by the majority of respondents were:

- Negotiation and setting up local contracts
- Supporting innovation and initiatives
- Ensuring that the pharmacy voice was heard in local health organisations
- Resolving and supporting contract breaches
- Ensuring community pharmacy representation in PCNs
- Supporting evidence collection to inform PSNC negotiations
- Representing community pharmacy in the local media
- Presenting the voice of the contractor to the PSNC

Whilst the majority of Independent contractors believed LPCs provision of information to optimise contract delivery and remuneration, maximising contract claims, regulation and monitoring of contract implementation and supporting contractors to implement new guidance were fairly or very important, CCA representatives believed these activities to be unimportant. AIMp responses were more aligned with independent contractors than CCA.

Independent and AIMp respondents believed that LPCs sharing good practice was important, CCA members were evenly split with respect to this.

Many contractors indicated they did not want the LPC to carry out any other roles, some expanding on this saying that this was sufficient / what they would expect the LPC to do. Others saying that LPC carries out a number of roles that are not within their remit and their time, or did not seem to have any tangible benefits for contractors (large numbers of meetings with other local health committees/teams) and resources would be better focussed elsewhere:

Some contractors wanted to see LPCs work more closely together or merge to reduce duplication of work in order to save resources and funds that could be redirected to support activities that could most benefit contractors.

Information Technology was seen as an area where LPCs should be investing their time supporting contractors.

For one contractor, the elected nature of LPCs was important: 'LPC is the elected contractor body. PSNC is not elected by the contractors and should be directed by the LPCs.'

Other contractors wanted LPCs to input to national negotiations with PSNC.

The LPC's local knowledge, insights and networks were key, and having this local voice represented within the new PCNs was important to all groups of contractors.

One contractor suggested LPCs could be a source of support for contractors in times of crisis and mental health issues.

Examples of good practice

Delivering services examples:

- Assisting the setup of PCN networks
- Support offered in launching flu jab and claiming payments for PQS
- Getting enhanced services extended
- Bridging the communications from local hospitals, for the creation of an electronic discharge system

Contractor support examples:

- Communication for national and local deadlines as well as regulatory matters.
- LPC Collaboration – there are several examples across the country where LPCs coordinate and share expertise to deliver local services and evaluations that have informed national contract discussions
- Contract engagement officers
- Support when changing ownership
- Good meetings to help with contractor compliance
- Helping those in difficulty
- Announced visits by support officers particularly to independents to establish need or wish for additional support.

Promoting community pharmacy

- PCN Championing Community Pharmacy as a solution for local challenges by collaborative working. Facilitating Locality togetherness
- Blogs and media articles promoting CP
- Help with leadership and pharmacy champions training

Recommendations for enhancement of LPC performance

Centralisation of some activity to PSNC

- National services should be done by PSNC
- Production of material done by LPC's could be done more efficiently at a national level
- Local service negotiations may be better done by PSNC as they have a better idea of what the national picture is like and may be able to secure better funding?
- PSNC should own the pipeline for service development with LPC stakeholders.

Centralised services within LPCs

- Benefits for LPCs to have a national based back office function, such as payroll and Human Resources, Supply of items needed to run an efficient LPC

Delivery of training

- Trade bodies can pick up provision of guidance and training,
- A business management type company could do better teaching and guiding through PCN's and the engagement and negotiation
- RPS and NPA and NHSE could take on some of it
- Clinical and skills training for new roles-probably better done by RPS or NPA
- Training for new services – would be better supported by CPPE

Miscellaneous

- Media contact
- GMC could negotiate better for pharmacies and enable them to be integrated into front line services

Funding

Approximately half of respondents stated that funded should be by contractors' Levy with a quarter recommending central government.

There were a handful of comments which stated if was voluntary they would not pay levy to the PSNC.

Varying levy fees in different LPCs was noted as was accountability of how money was spent.

A few, including three large CCA contractors stated that the levy should be paid to PSNC then devolved down.

Section 3 Views on local LPCs

The data represents responses from 65 AIMp contractor representatives, 155 CCA contractor representatives and 523 independent contractors.

Overall satisfaction with the individual LPCs was approximately 65%.

Approximate satisfaction with each of the following was:

- | | |
|----------------------------------------------------------------|-----|
| • Value for money | 55% |
| • Understand how my LPC makes decisions | 60% |
| • Able to hold my LPC to account | 50% |
| • Represents my voice locally | 60% |
| • Understands my needs | 60% |
| • Size and structure enables effective engagement with the NHS | 45% |
| • LPC links has resulted in tangible outcomes | 50% |
| • Satisfied with communication | 70% |

Independent contractors are always more satisfied with their LPCs and different elements of it than CCA or AIMp respondents.

19. LPC national survey results

The following section is a summary of the main findings from this element of the review. All data obtained from this survey is available in Appendix XV.

68 out of 69 LPCs completed the survey.

LPC membership and employees

A mean of 12 voting members was reported on LPCs with the majority between 11 to 15 in size. The minimum and maximum sizes reported between 8 and 20. Only 4 committees had a voting membership of greater than 15.

51 (75.0%) reported that all members had been involved in developing their response. Where disagreement between committee members was unresolvable, many chose to upload comments that represented the different positions.

15 (22.1%) reported having a current PSNC member on their LPC with 6 (8.6%) reporting a previous PSNC member. Having a PSNC member on the committee was associated with a small but significant increased positivity towards the PSNC.

The mean (SD) maximum number of years as a continuous committee member was 21.3 (8.3) with a small number reporting members who had been on the committee for 40 years or more.

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.

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.

LPC committees meet at least five times per year up to a maximum of ten times (approximately every month except August and December).

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.

There was a recommendation of an initial five-year fixed term contract for Chief Officers.

55 (77.9%) reported that the Chief Officer could not be a member of the committee to ensure good governance and avoid conflicts of interest.

58 (85.3%) stated that the selection of Chief Officers should be standardised.

42 (61.8%) believed that the LPC should reflect the diversity of its contractors and contractor representatives.

The majority of comments thought that the current size of LPCs was appropriate, however, these were largely LPCs stating they had 200-300 contractors

Recognition that geography (physical and NHS & Local Authority (LA) structure) were important in making decisions about size

Noted that if LPCs become too large they will lose local relationships.

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' contractor figure and the need to base the final number on geography and local relationships.

44 (64.7%) shared functions with other LPCs. Many LPCs described sharing agreements (whether formal or informal) in terms of staff, communications or training.

Monitoring of employees for up to date training in GDPR was reported in 40% of LPCs, 27% recruitment and appointment and 17% equality and diversity.

LPC committee members i.e. non-executive, 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'.

LPC roles and responsibilities

Less than 30% of LPCs believed that clinical, management or leadership skill development were a responsibility of LPCs.

With respect to training the consensus was that

- LPCs should not provide any other training from levy funds
- LPCs should provide local training only when it applies to all contractors and these funds should be obtained from the service commissioner.
- The appropriate body should be used to deliver the appropriate training e.g. clinical skills – CPPE, leadership – contractor themselves.
- LPCs should not provide training that is within the remit of individual contractors

'LPC supported' but not 'contractor funded' was a common theme.

Greater than 70% of LPCs believed that they should be involved in supporting changes to contract, 80% implementation and delivery of national services and 90% implementation and delivery of local services. Figure 16.1 summarises LPC views on the relative importance of its different roles.

Additional comments surrounding this include:

- 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
- 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

Communication

A range of methods and frequency of communication by LPCs was reported. A small proportion never used social media or newsletters.

Comments relating to how communication can be further enhanced included:

- Reduce duplication – focussed communication (focus on local)
- Use different channels e.g. WhatsApp, Podcasts etc.– more digital methods
- Conference calls and webinars
- Must encourage two-way communication
- Focus on pharmacy/contractor engagement and how to improve it

LPC governance and accountability

53 (73.5%) of LPCs believed that there was a need for external oversight.

There was broad agreement that there should be a national standard and that this should include a code of conduct based on the Nolan principles.

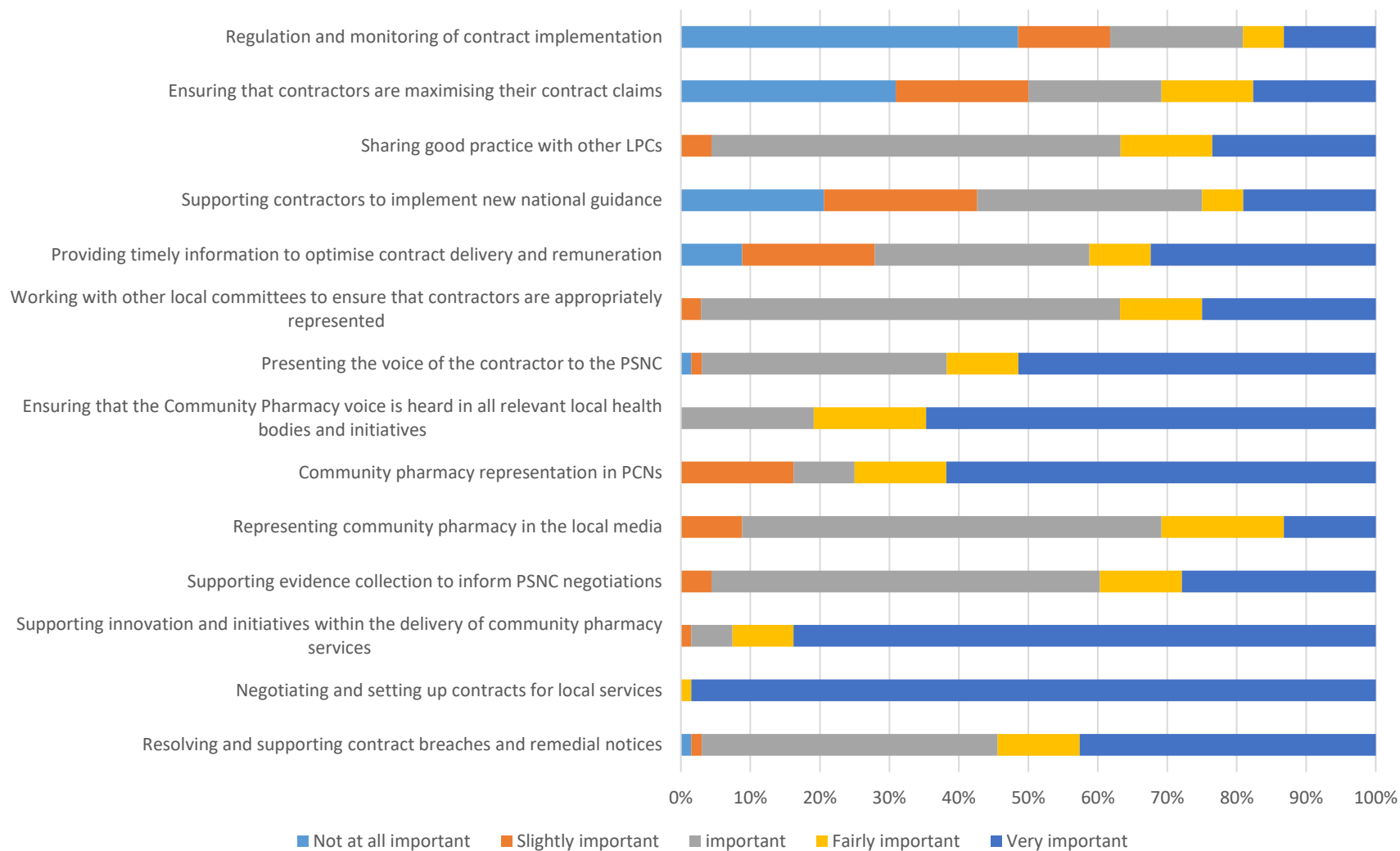
Many LPCs reported that external oversight was achieved through their contractor members particularly by the publication of their annual report and accounts.

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.

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.
- 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.

Figure 16.1 Summary of LPC views regarding the importance of different roles it can potentially undertake



LPC performance

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.

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 [for governance and performance] to ensure consistency across all LPCs.

Funding model

There were three broad ideas reported in this section:

- Keep it the same as it is now.
- Fund PSNC and let the money come down to LPCs (one person mentioned the worry about the RPS model here where LPFs have disappeared).
- 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.
- Agreement that 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.

LPCs views of the PSNC

Figure 16.2 provides a summary of LPC views on the PSNC.

Respondents were unsure what the vision for community pharmacy is and that if there was one it needed to be better articulated.

The PSNC was not believed to have the skills to realise the vision.

There was a feeling that the vision is dictated to PSNC by NHSE&I and DHSC.

One response classified the current vision as “uni-professional and transactional rather than relational and multi-disciplinary”.

With regards to a strategic plan there were similar concerns regarding whether there was one, that LPCs didn't know what it was and that they need to be involved in its development.

With regards to decision making there was almost universal belief that there was little transparency within PSNC and its decision making, with 'secrecy' a major concern.

LPCs and contractors should be able to hold PSNC committee to account and at present there is no clear way to do this

There was recognition that there was no input into decision making for the average LPC or contractor.

In relation to the governance of PSNC committee the majority of responses centred on a lack of information available about whether to judge this as appropriate.

Most articulated a need for open and transparent information regarding internal PSNC structures.

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

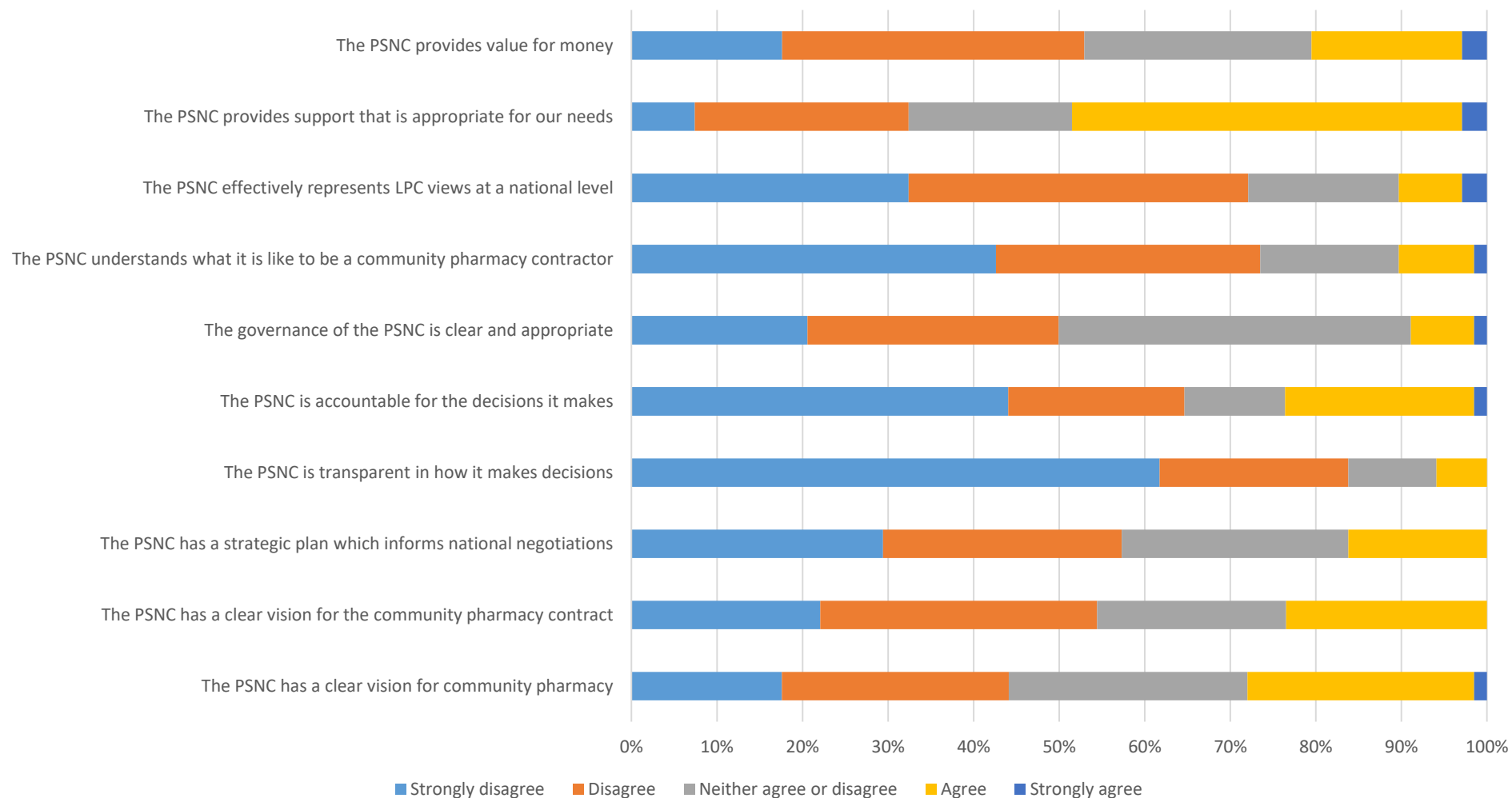
- LPCs not asked for their views – no questions or comments asked for by PSNC.
- Hard to communicate upwards.
- Some reported a good experience with their PSNC reps.
- Sometimes feedback to the PSNC can be taken in a defensive manner.
- The PSNC committee present their views not those of contractors or LPCs.
- PSNC overly represents a small number of (louder) LPCs.

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

- Good website and resources.
- 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.
- If you ask the PSNC for it and you will get it.

It was noted that the PSNC could engage in providing more support.

Figure 16.2 LPC views regarding PSNC



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.

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
- Good website
- Improved relationships under the new CEO
- Good at reacting to changes imposed

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 [internal] 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, AIMp, 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:

- Greater transparency and engagement to build trust and openness
- 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'
- 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

Response to independent review

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:

- 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

Those that stated a preference believed that implementation should be between Oct 2020 and the end of 2022.

20. Summary of PSNC Member interviews

25 interviews undertaken out of a potential 31.

The questions resulted in five main areas of discussion. There was significant consensus on most topics.

The committee

The overwhelming majority of interviewees believed that the PSNC committee was too large for a committee which is required to make large numbers of decisions. One described it as 'Bonkers'. A small number supported its current size and its effectiveness stating that it allowed all issues to be fully considered. The time required for this level of consideration and focus on detail was also seen as a negative.

Engagement by PSNC members was also seen as variable, with more than one member citing the rule of thirds 'one third being very effective, one third making a contribution and one third adding very little'. The comment that certain members were more vocal than others and contributed more than their fair share was frequently made. A hierarchy of people listened to was believed to exist. The word 'stagnant' with respect to the PSNC was used on more than one occasion, as was the recognition that a number of members had 'baggage'. Most members believed that a committee size of between 10 and 20 would be more appropriate.

The current frequency of PSNC meetings, quarterly, was seen as insufficient given the pace of change.

Unsurprisingly all members stated that if the committee size was to be reduced it had to either represent proportionally the number of contractors (CCA and AIMp members) or remain as is, with equal weight given to independents and multiples (Independent members).

Voting for what was best for the member's employer or themselves individually was recognised as contrary to the PSNC code of conduct. Better recognition and management of conflicts of interest was requested. There was acceptance that the role of the PSNC was to do what was best for contractors overall.

A number of interviewees expressed concerns that some PSNC members no longer practised at the coal face and therefore did not fully understand what it was like to be a community pharmacist on the front line.

Most members recognised the need to limit the number of terms for members citing the need to allow others and younger members to join. There was agreement that due to the complexity of the subject, time was required to 'get up to speed with the concepts and processes'. It was felt that three years were needed just to settle in and become familiar with the PSNC and how it operates. There was also value in institutional memory and consequently longer term of service was appropriate. Where a preference was stated it was usually for three current terms i.e. 12 years.

A number of members believed that ineffective members should be automatically asked to stand down i.e. those who do not routinely contribute to discussions.

A large number of interviewees believed that the PSNC had to be more inclusive and should be bringing in external expertise whenever necessary. It was too reliant on believing that all of the expertise required for all decision making could be found within the 31 members.

There was recognition that the PSNC members undertook exec and non-exec functions which was unusual and reflected the fact that not only were they providing oversight and making decisions (non-exec roles) members frequently got involved in delivery (exec roles). This resulted in significant workloads associated with PSNC for some members which was delivered either through the support and goodwill of their employing organisations or in their own time.

The sub-committee structure and working was largely disliked due to organisation and a desire by many members to be on more than one committee, although they frequently ran concurrently. There were comments about members trying to attend and observe all sub-committees. The time given to sub-committees was too short. There was a recognised need to join them up better, to have more of them to give a more rounded view of community pharmacy and use them to develop policy. Their role should be to identify what is required within the negotiation process.

Interviewees identified that PSNC did not consider workforce in its current deliberations with some believing that this was part of its role and others believing that it wasn't.

A reasonable number of interviewees believed that the whole PSNC structure should be scrapped and started again. One member stated that change needed to be 'seismic'.

There was recognition of the fact that contractors and LPC members didn't know what they did and that they needed to identify ways to better engage with the 'grass roots'. The recent roadshows were frequently cited as one way to achieve this.

A good number of interviewees recognised that the PSNC had traditionally operated as a secret organisation, letting little information out of its walls. The approach by the new CEO regarding greater transparency both within and outside of PSNC was supported and applauded. One interviewee used the word 'Kremlin' to describe how the PSNC was perceived by LPCs and contractors.

There was recognition that more joined up working with LPCs would increase the strength of the community pharmacy voice.

Members largely agreed that the PSNC did not have a vision or strategy for community pharmacy and one was needed. One member stated that 'we tried to put one together but could not agree between us'. It was recognised that any vision had to align with that of our main customer 'the NHS'.

The Negotiating Team

There was agreement that members of the Negotiating Team had conflicts and that they were not as one as a team with different perspectives driving their position when in the negotiating room. This was recognised as unhelpful in securing the best outcome for contractors. A number of interviewees recognised that the current team were not professional negotiators, whose day job it is to do this and for which they have sufficient training.

There was a recognition that the PSNC had to have a united front but at the same time it had to listen to its main customer, the NHS, with respect to what it wanted from community pharmacy.

A lack of preparation for the negotiating process was identified i.e. it was seen as more reactive than proactive. Surprise was expressed in the fact that the team does not seem to go in with its own list, broken into red line items, good to have and nice to have items. This approach enables more effective negotiations. Currently the process was seen as very one sided with NHS England providing its wish list only.

A number of interviewees suggested that the PSNC should employ professional negotiators.

There was repeated recognition of the asymmetry of power between the NHS and community pharmacy and that this made it difficult to negotiate effectively.

The recent effective BMA negotiations on behalf of general practitioners was frequently seen as being due to them being doctors and having greater leverage than pharmacists.

The majority of interviewees believed that the PSNC needed to get better at negotiating and the current model of appointing members to the negotiating team was resulting in a status quo which was not ideal.

The job of negotiating has increased significantly over time and is now almost continuous. Consequently, the time commitment for the team was significant and due to the constant nature there was no longer time to agree a stance or view point. The current model of Negotiating Team members giving up a lot of their time was not seen as sustainable.

Those members who were not on the Negotiating Team frequently described the process as opaque and frustration at not being privy to the conversations or process.

A need to develop better working relationships with NHS England was identified as this would ultimately help the negotiation process.

PSNC Employees

Views of PSNC were overwhelmingly positive stating their strong work ethic, collegiality and desire to deliver.

There was complete agreement however that the PSNC head office was under resourced, employees were significantly overloaded and that the lack of succession planning was a major concern. Repeatedly different employee names were mentioned and then followed up with 'the system would collapse if they were to 'retire', 'choose to work somewhere else' or 'go under a bus'.

There was also some recognition that some of the PSNC employees had been in the same position for a long time and that this gave them no career progression opportunities. It was also recognised, that by staying in the same role for many years, this potentially created a culture which was resistant to change.

There was recognition of the fact that the lack of resources resulted in the PSNC being largely reactive and not proactive.

Many of the members from the multiples indicated that they provided data analytical support to PSNC to inform discussions and negotiations. They funded this from their own resources and not from PSNC.

Interviewees agreed that PSNC required significantly more funds to be able to operate effectively. With a number citing the fact that a greater proportion of the levy should be centralised as the national contract is what has greatest impact on contractor income. There was a realisation that with the current funding squeeze on contractors this review should not result in an increase in levy for contractors i.e. the current money had to be used better.

There was agreement that the current ability of LPCs to withhold funds was unhelpful and inappropriate given that the PSNC was responsible for negotiating the national contract.

PSNC members frequently believed that the levy should go to the PSNC and then be paid out to LPCs i.e. reverse the current model. A much smaller number however liked the fact that the PSNC was accountable to LPCs.

PSNC effectiveness

Most believed that negotiating a five-year contract was a positive step, although the fact that inflation was not included within this was recognised as a problem. It was noted that it was 'fascinating that we negotiated a five-year deal with no idea as to where we wanted to be or were likely to be at the end of this period'.

Setting up the new consultation service to reduce burden on GPs and A&E was seen as a success and as finally providing some leverage for community pharmacy within negotiations with the NHS.

The PSNC was recognised as starting to work more strategically with RPS, NPA and CCA and this was seen as necessary to create a unified front.

Local Pharmaceutical Committees

There was agreement that there was a need for local representation for community pharmacy within the NHS and that most innovations with respect to new services are generated locally. Consequently, PSNC members unanimously supported a LPC network.

LPCs were however seen as variable with respect to their effectiveness and quality of governance. In some cases, they were believed to be inefficient. Support for better governance and key performance indicators both within LPCs and the PSNC was stated by most interviewees. An independent governance body which oversaw the process was preferred to the current 'optional' arrangements.

Chief officers were seen by some members as having too much power within LPCs when they should be accountable to the chairperson who is an elected member and a contractor. Pro-rata salaries of up to and beyond £100k were cited on a number of occasions with questions raised as to whether this really provided value for money for contractors. Financial governance and transparency within some LPCs was a real concern.

The constitution for LPCs was seen as too broad and there was a need for better definition of role. Supporting contractors to meet their contractual targets was commonly cited as an inappropriate role for LPCs as it was duplicating work already undertaken within multiples

and therefore essentially using levy to preferentially support independent contractors. One interviewee was concerned that LPCs were seen as 'head offices for independents' and that this was entirely inappropriate given the funding arrangements. There was agreement that LPCs should focus on local commissioning of services as this is where the innovation and eventual national services come from.

Development of local service templates, contracts and evaluations was seen as duplicative and inefficient and should be supported by a national structure to enhance efficiency. All national templates should however be developed with significant input from LPCs.

There were a number of recommendations made to enable PSNC to share resources with LPCs and enhance efficiency.

Interviewees frequently believed that LPCs needed to be bigger to reduce the proportion of income used for committee and Chief Officer costs. London, Manchester and West Yorkshire LPCs frequently cited as good models of federated and merged larger LPCs. There was also a belief that there were too many LPCs for the PSNC to effectively engage with.

LPCs were not seen as effective at negotiating contracts which provided sufficient profit to warrant the workload and effort involved. Unless set up as pilots, all local contracts should have a sufficient profit margin within them.

There was recognition that there was distrust between the PSNC and LPCs and that this went in both directions. Processes to reconcile the two and address the cultural differences were required. Bringing LPCs closer to the PSNC was recommended.

The regional representative role undertaken by 13 member of the committee, all independent contractors, was seen as difficult to deliver effectively due to the size of the regions and the fact that the regional representatives all largely had full time day jobs in addition to this role. Whilst the role was also largely unremunerated it was clear that all of those who undertook this were passionate about the need to engage effectively with LPCs. It was questioned whether the provision of regional roles only to independent contractors was appropriate.

The conference between PSNC and LPCs was seen as very important but there was recognition that this needed more time for discussion.

Ideas and suggestions (from at least one individual)

- To improve our use of patients to strengthen our voice. Noted that doctors are better at using them than pharmacists.
- To develop an external communications strategy in addition to an internal one
- To enhance our effectiveness at lobbying and working with MPs
- To allow observers within the PSNC and LPC when meeting to help individuals to better understand how they operate
- PSNC to set up a HR function which would be used internally and support LPCs
- To bring in external experts more frequently into the PSNC and not try to do everything in-house. To reach out more to LPCs across the country.
- Use professional negotiators or train members of negotiating team better
- Allow LPCs to vote on the final contract in a similar manner to LMCs and the GP contract
- Train PSNC members in how to be an effective board member
- Develop and implement strategies to create our leaders for the future
- Develop and implement a code of conduct for PSNC members
- Provide guidance as to what a Chief Officer salary should be given the national job description
- All PSNC documentation to have an executive summary which explains the main issues and points in plain English
- Set up a national provider company to overcome the inefficiency of lots of local provider companies being set up by LPCs
- Change the name to Community Pharmacy England to better describe the PSNC's role which is wider than negotiating.
- Strategy needs to be separated from negotiations and policy, possibly through a different arm or committee

21. Summary of PSNC Senior Employee interviews

Five interviews were undertaken.

1. Common themes

- Roles are predominantly reactive
- Workload pressures are significant with no spare capacity in the system
- Increasing demands from all directions no increase in staffing
- Unrealistic expectations with respect to what can be delivered
- Large number of ongoing developments which require PSNC expertise but again capacity limited
- Training provided by PSNC to LPCs recognised as important for reducing risk in the system and enhancing quality
- Variation in quality of LPCs with respect to outputs, demands and risk
- No succession planning in the system
- Systems anachronistic and do not allow entry to younger people

2. Positive messages

- Training provided to LPCs from PSNC well received and accessed (although all stopped now due to lack of resources)
- Joined up working with NPA, CCA, AIMp with respect to communications happening but again limited resource to drive this

3. Ideas & suggestions

- Chief officers have significant responsibility for effectiveness of LPCs and consequently better and more standardised appointment processes required
- Chairs to be effectively trained for role within in LPCs to ensure good governance
- All LPCs to have a communication/media lead to enable support for a national communications strategy
- Create national/standard service specifications, business cases, costing templates, data collection forms, promotional material + other relevant tools to increase standard and reduce duplication
- PSNC to work more closely with LPCs to prevent duplication of effort. Examples provided:
 - PSNC provides guidance then LPCs rewrite it for their contractors. This is highly inefficient. Materials should be fit for purpose at the initial point of production
 - PSNC provides materials to support Pharmacy Quality Scheme and LPCs then edit and change them which again results in duplication of effort and inefficiency
- Focus on IT strategy and systems to support contractors
- Facilitate and encourage better use of IT within PSNC and LPCs to enhance efficiency
- Creation of human resources team at PSNC to support internal and LPC staff management and support
- Create a vision and strategy for Community pharmacy in England

22. Website review

Website review procedure

Sixty-nine LPC websites were reviewed (all those that are linked to on the drop-down menu that can be found at <https://lpc-online.org.uk/>). This review was conducted between 17th January 2020 and 2nd March 2020. The process was piloted on seven websites and findings discussed with the whole review team before proceeding to review the remaining 62 websites.

Main Findings

1. Website functioning & date of last additions/updates to website & who hosts it

2 LPC websites could not be found / the links were not working (this has been checked and is still the case at time of writing this report).

For 36 LPC websites, information had been added in the last month, 19 had been added to in the last 2-6 months, 6 had been added to in the last 7-12 months, 6 had not been added to in a year or more – with one website not being added to since 12/12/2018 (over 2 years).

Fifty-one of the websites were hosted using the PSNC platform, 2 were broken so it is unclear who hosts those, and the remaining 16 had created their own using a blogging platform / commissioned their own.

NB: The results that follow on from here are findings are based on 67/69 LPCs who had functioning websites

2. Information about the LPC

Governance expectations

Annual report: 21 had not published their annual report for 2018-19, 42 had published their annual report for 2018-19, 4 had restricted access to most of their website for LPC members and contractors who had a log-in and so it was unclear if the annual report was behind the log-in page.

Governance documents and governance self-evaluation: 7 had governance documents and an up-to-date self-evaluation completed. 13 had governance documents (no set date) but had not done any self-evaluation, 10 had governance documents, but the self-evaluation was out of date (2018 or earlier). 33 had no governance documents (of these 4 may have had these behind log-in pages).

LPC accounts: For 25/67 LPCs there were no accounts available. So what follows is based on the accounts of 42 LPCs that accounts that it was possible to access. Figures are rounded up to the nearest £.

LPC income: For all LPCs the bulk of income was from the contractor Levy, however, on average the LPCs reported an extra £23,595 of income (range £73-£208,892). All had reported bank interest as a source of additional income, other sources included funding from local NHS organisations for pilot services, sponsorship for training (e.g. from industry), PharmOutcomes money, AHSN / HEE monies for specific projects.

Amount of money in LPC reserves and underspend: On average LPCs had £145,221 of funds held in reserve (range: £35,443 to £611,538). In 2018-19, 27 LPCs reported an underspend and the average underspend across these LPCs was £19,403 (range £93- £58,758)

Fourteen LPCs reported spending of their reserves and on average this was £7,213 (range: £354-£88,617).

For one LPC the spending against income was not stated as full accounts were not available.

Additional information

Number of contractors: 49 LPCs did not state how many contractors they represented

Strategy documents: 34 had an up-to-date strategy listed on their website, or found in their annual report. 30 had no strategy listed on their website or in their annual report (this includes the 4 websites that had access to their LPC website behind a log-in page) and 3 LPCs had a strategy document but it was out of date and it was not clear if they were still working to this strategy or not. 33 LPCs had no social media or twitter feeds which had been inactive for many months (sometimes for several years).

Communicating with contractors using social media: Most LPCs communicated with their contractors via email and newsletter, but social media was in use. 36 LPCs had active twitter feeds (tweets in 2020) on their websites, 3 had inactive twitter feeds and 7 had no social media feeds on their website. These were predominantly twitter feeds, but there was one LPC that reported using Whatsapp, and another that also used Facebook pages and had a podcast too. For 18 LPCs (including the 4 which had a log-in page to access the LPC pages) there was no evidence that online or face to face training was provided in the last year / that any training was planned for 2020.

Resource provision

Training: 28 LPCs reported providing online (usually through virtual outcomes) and face-to-face training opportunities for contractors and pharmacy teams. 12 LPCs had provided face-to-face training in the last year and/or had face-to-face training listed for 2020 onwards. 8 provided online training.

Primary Care Networks (PCNs) and Pharmacy PCN Leads: 49 LPC websites (or newsletters) had information about PCNs and of these 49, 43 had information about the local pharmacy PCN leads, and 6 had no local information. The remaining 28/67 had no general information about PCNs or local information about Pharmacy PCN leads (for 4 sites this may have been behind a log-in page).

Information on the 5-year contract: 42 had information about the 5 year contract on their webpages, in the main, this was minimal explanation with links to further information on the PSNC website, but some LPCs had localised and digested the information further for contractors. 25 had no information, or out of date information about pharmacy contracts (e.g. had information about national pharmacy contracts that had now been superseded / expired)

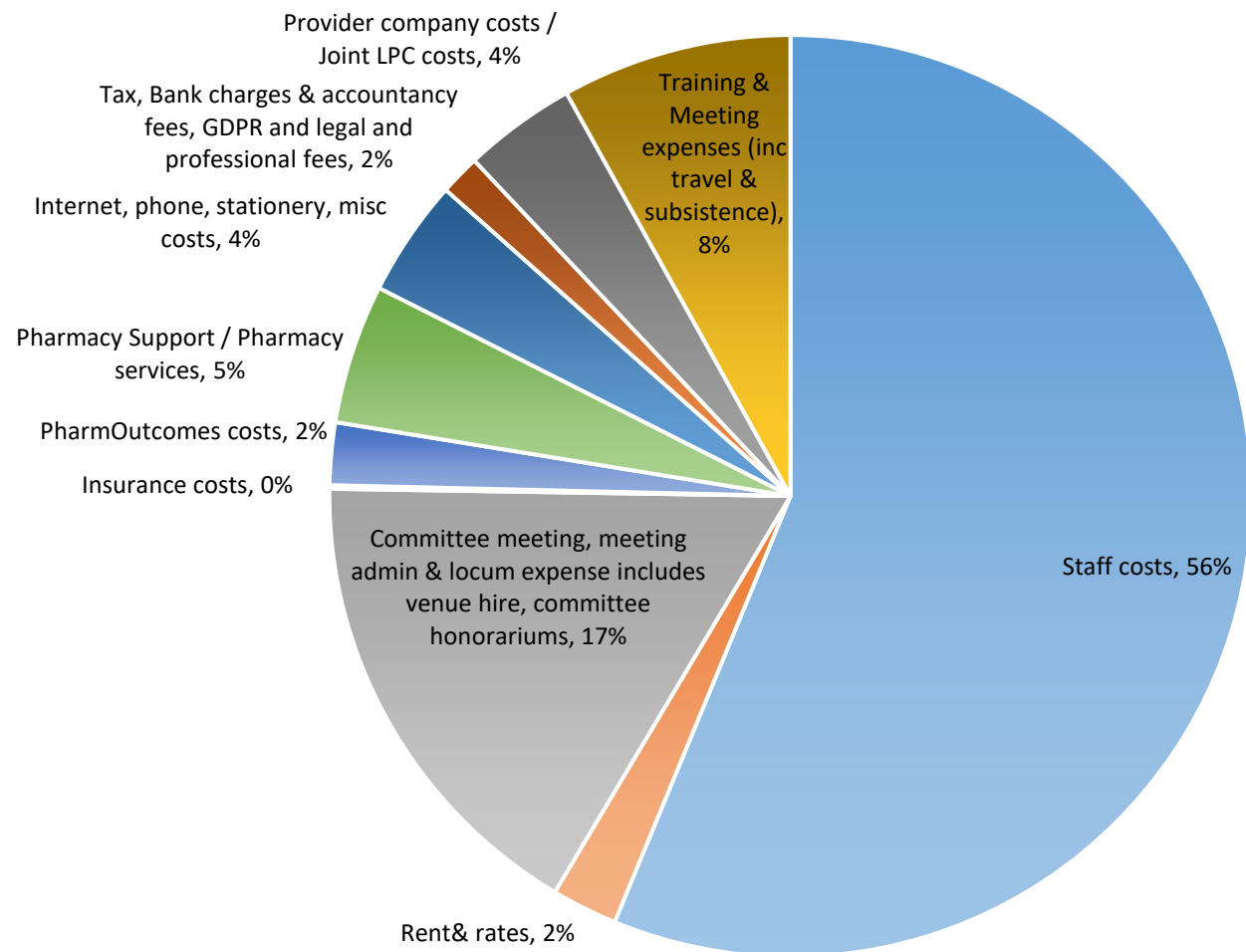
Resources for Advanced services: Only 4 LPCs had no information about advanced services on their website, the other 63 had information, and of these, 5 only provided information on some advanced services and the information provided was links to PSNC pages, 4 had

provided PSNC links, but had also adapted information and provided further resources and information in a summarised manner, 54 had provided links to PSNC for each of the advanced services.

Resources for locally commissioned services: Seventeen LPCs provided no, or very out of date information (including broken links) about locally commissioned services (again for 4 websites, this information may have been behind a log-in page). 6 LPCs had some information about locally commissioned services, but some of this information was out of date. 46 had good resources for locally commissioned services.

Resources on the Pharmacy Quality Scheme: 23 LPCs did not provide any information about PQS (for 4 this may have been behind a log-in page). 42 provide information, and this was primarily through links to PSNC / NHS pages. Two had provided more detailed local information and resources beyond the PSNC pages.

Figure 19.1 Spending by LPCs



23. Other pharmacy representation models (Wales, Scotland)

Community Pharmacy Wales (CPW)

National structure

- CEO
- Director of contractor services + 3 pharmacists – all practising.
- Finance lead.
- Office manager and assistant.
- Represent over 700 contracts held by 150 contractors.
- No regional structure.
- Committee has 13 members, six from independent contractors, six from CCA member contractors and the member of the PSNC.

Negotiating team

- Only take CEO and head of contractors into negotiations.
- Planned to change in the future to include one member from the independent sector and one from the multiple (CCA) sector.

CPW ethos

- CPW acknowledges that the network's main customer is NHS Wales and that the network needs to provide the services that NHS Wales requires.
- CPW seeks to tailor service specifications to meet the needs of local populations.
- CPW board members sign up to voting for what is best for community pharmacy generally.
- Trade associations do not have representatives on the CPW board.
- Board members represent contractors and are required to act in the interests of the contractor network as a whole.

CPW activities

- Service specifications are designed jointly with service commissioners which are either Welsh Government or Local Health Boards. There is general agreement in Wales that a single service specification with a single fee across Wales works best but there is scope for local differences if the needs of the population demand.
- Health boards commission services.

Engagement with contractors

- Two cycles of contractor roadshows and surveys per year
- Weekly newsletter.
- Certain areas have different needs.
- Three member of CPW executive team (Associate directors) oversee contractor engagement and do so in person in the pharmacy, by phone or email.
- Some contractors don't value what CPW do for them, whilst others do.
- Meetings every six weeks with those contractors who sit on CPW board, committees, Health Board Forums and Task & Finish Groups.
- CPW is open to suggestions but favours universal services across Wales.

Community Pharmacy Scotland (CPS Ltd – Company Limited by Guarantee)

National structure

Employed team:

- Chief Executive Officer
- Director of operations
- Head of policy and Development
- Policy and Development Pharmacist
- Digital communications officer
- Communications assistant (website / newsletters)
- Head of pharmacy services
- Data Analysts (x2)
- Pharmacy services team of eight staff to support contractors
- Governance officer
- Executive Assistant
- Administrative Assistant
- One field based role to support Health and Social Care integration

Board

- 15 members with chair and vice chair selected from within.
- No protected places or proportional representation for different types of contractors. Currently 9 independent contractors (elected) and 6 CCA representatives. (nominated)
- Meets monthly
- Chair and vice chair paid stipends
- Ltd status for CPS to protect board and council from personal liability

Council

- 42 members on council all come from 14 regional health board pharmacy committees. Number of places based on number of contractors represented.
- 6 monthly meetings
- Board presents negotiating strategy and asks council for mandate

Relationship with NHS Scotland

- Supportive chief pharmaceutical officer and team who understand network
- NHS Scotland understand business
- Current contract consists of a three-year deal with inflation year on year
- Three year allows services to develop in between e.g. Given a year to revise medicines care and review before introduction

Negotiating team

- Chairman, vice chair, senior CCA member, independent contractor (all board members) plus expanded CPS Executive staff team
- Team trained for role
- Monthly government meetings with negotiating team with focus on service development

Negotiations

- CPS start from its principles and vision rather than money
- Members there to represent community pharmacy not their employer

Current example of success

- Payments for students to get involved in the network
- Negotiated that completion of Foundation program for community pharmacists leads to automatic prescribing place
- Contractors paid to take foundation students from within their Global Sum
- Current trial to pay for pharmacist prescribers to work in community pharmacy at £2000 per month. Longer term plan that they are self-sustaining but to pump prime the process.
- Health boards are placing pharmacy technicians into community pharmacies for training

Local pharmaceutical committee structure

- Aligned with health board areas
- 14 Community Pharmacy 'Health board' (CPHB) representing 1,257 contractors
- Variation in number of contractors represented from 250 to 8
- Size of committee dependent on number of contractors represented

Relationship with Community Pharmacy Scotland

- Perceived as good
- CPS provides advice on to CPHBs
- No control over CPHBs
- CPS created a vision which aligned well with Chief Pharmaceutical Officer vision therefore facilitating negotiations

CPHB Effectiveness

- Perceived variation in effectiveness
- Local negotiations could be better with some poor locally set precedents
- Example provided of a locally set up service not translating nationally

24. Other representation models (Medicine, Optometry)

General Practitioner Committee England (GPC England)

Within England there are approximately 110 Local Medical Committees (LMC) which are divided into 55 regions (essentially 2 LMCs per region). Each region nominates one member to join GPC England

The voting membership of GPC England Committee consists of the GPs from England who are elected on to GPC UK:

- 36 regional representatives, tend to be LMC officers/members
- 10 GPs elected by all of BMA representatives
- 7 National LMC conference representatives – elected by representatives of UK LMCs
- Four sessional representatives – salaried or locum GP
- Two trainees
- Two GPs from the Unite Union
- One GP representing Prison Doctors
- One GP with in first five years of completion of their training
- One member from British International doctors' association
- One member from Medical Women's association

The committee meets four times a year for one-day conference at different locations across England,

Half a day is spent debating the main current issues and half a day working in one of the eight policy groups. The GPC members select at the start of the year which they would like to be part of, but ultimately they are allocated to ensure equal numbers in each group;

The policy groups are:

- Premises and practice finance
- education, training and workforce
- dispensing and pharmacy
- commissioning and provider development
- clinical and prescribing
- Information management, technology and information governance
- contracts and regulations
- representation (GPC governance with respect to this)

There is a significant communications team at the BMA of which two are allocated to the GPC for day to day support.

The executive for GPC England consists of four members (including the chair) who are employed two days per week. The term of service for the chair is currently three years and they can only be in place for two terms.

The membership of GPC itself has no maximum time limit. There is however a current review looking at introducing maximum term of membership with a break required after this.

There is a secretariat, employed to support the executive team. These are highly qualified, non-medical individuals who are employed to undertake preparatory work for the executive and policy teams.

Funding

GPC England has two funding streams, the British Medical Association and contractor levy. Similar to pharmacy a proportion of the levy automatically goes to local medical committee and a proportion is 'optional' which goes to GPDF (General Practitioners Defence Fund) that funds GPC England through a grant paid to the BMA. This can be withheld by individual LMCs.

The negotiating team

Consists of four negotiators, three GPC representatives (although anyone can be appointed as negotiators by the chair) and the GPC England chair.

The chair selects the Negotiating Team. The process is as follows:

- GPC and LMC representatives put themselves forward for selection
- There is a two-day rigorous selection process led by the chair
- The three successful candidates are then intensively trained in negotiating skills, equality and diversity, leadership and media amongst other things.
- Each year the team goes into retreat with GPC England staff to reflect on the year and their performance and prioritise work set by grassroots policy

The chair has selected a team this time which consists of a broad range of skills from technical know-how to passion, and in depth knowledge to being able to think quickly on their feet. They have been deliberately selected due to their potential for effective negotiation but also their different skill sets. There is also a good age range, race and gender distribution in the negotiating team.

Within the negotiations with NHS England they are very much one team with no divisions between them within the room. There is one voice and one vision backed up by contractors. This was described by 'we *gel* really well'. GPC England staff are present to support the negotiating team but do not speak in the negotiations.

When the chair changes the negotiating team also change as it is the prerogative of the next chair to select their own negotiating team.

Performance

2013 was the last time that a contract was imposed on GPs. The imposed contract was a failure and NHS England have been far more open to real negotiation since this occurrence.

General Practitioners, in recent years, have been very effective at negotiating their national contract.

In 2020 GPC England signalled to NHS England that they did not like the initial offer, NHS England made some concessions and the template for a contract, after negotiations, was then agreed. The outcome was a significant increase in income, additional funds for workforce support and development, rejection of a request to visit care homes every week and a pairing back on the requirements for structured medication reviews.

What was interesting from a pharmacy perspective was that GPC England then took this back to their committee (LMC representatives) for sign-off. Whilst the latter element is reasonably well-known the initial rejection also came from initial presentation of the offer to the GPC England committee i.e. the LMC representatives. In this model therefore Local Medical Committees are involved in initial offer review and final contract sign off. Essentially Decision making is far closer to the contractor in the medical model than in the pharmacy model.

After the new contract is agreed representatives from GPC England deliver roadshows across the country to engage contractors.

Local Optical Committee Support Unit (LOCSU)

LOCSU is an organisation wholly funded by levy from Local Optical Committees (LOCs) with three equal shareholders them being the three main sector representative bodies, the Association of Optometrists (AOP), Federation of Ophthalmic and Dispensing Opticians (FODO) and Association of British Dispensing Opticians (ABDO).

LOCSU's central aim is to support LOCs in their core activities and to offer advice as needed. Recently LOCSU have become much more involved in commissioning support to LOCs through the Primary Eyecare Company (PEC - Provider Company) model which has seen a growth in extended services being commissioned from optical practice.

Whilst PECs were initially set up to be individually aligned with LOCs, experience showed that it was better and more efficient to create one national provider company.

Now that the PEC model is well established and continues to evolve LOCSU is spending more of its time working with LOCs to formulate a response to the NHS reforms and specifically to understand how LOCs can work effectively with emerging Primary Care Network (PCN) and Integrated Care System (ICS) groups. This was the focus of the National Optical Conference (NOC) in November and the workshops from that event will form the nucleus of LOCSU support offer to LOCs over the next 2-3 years. In addition, LOCSU provides the following services:

Administration of Quality in Optometry (QiO)

QiO is funded by LOCSU on behalf of the Optical Confederation. QiO is a series of online check lists that optical practices work through in order to satisfy themselves that they are working in line with relevant legislation. It is mandatory for all GOS providers to deliver the GOS checklist every three years. Consequently, QiO is core to the delivery of the GOS contract.

Wales Optometry Postgraduate Education Centre (WOPEC)

WOPEC from within the University of Cardiff, is funded by LOCSU on behalf of the whole sector. The codes allow LOCs to be able to deliver training to their members in order to facilitate the delivery of extended primary care services, MECs etc.

Primary Care Support England (PCSE)

LOCSU is continuing the deliver support around the PCSE process as well has hosting information for practitioners via the LOCSU website. In addition, LOCSU also has a member of staff permanently seconded to PCSE supporting the transformation work on behalf of the optical sector.

Clinical Pathways

LOCSU is responsible for writing, updating and innovating a suite of clinical pathways to deliver extended clinical services in optical practice. These pathways provide the core of nearly all of the services currently being delivered and are being evolved to take into account the potential for new activity, for example advice and guidance, virtual clinics and clinical triage. The pathways are available to use via the local LOC and are designed ideally to be delivered within a PEC structure.

National Representation

LOCSU represents the sector on a number of national committees and organisations, for example the Clinical Council for Eyecare Commissioning, and continues to argue for the extended use of optical practice and a role for LOCs within these roles.

Primary Eyecare Company (Provider company)

LOCSU provides governance oversight to the PEC via its membership of the organisation. This is to assure the constituent LOCs that PEC are operating in the sectors best interests. In addition, LOCSU provides some administrative support, including accounting support, to the PEC.

Commissioning support

LOCSU continues to provide tailored LOC commissioning support and advice as needed via the Optical Lead team. In addition, we are commencing a program of regional LOC forum meets to address issues that crosscut all LOCs and to facilitate cross-LOC engagement with PCNs and ICSs.

Training and education

LOCSU provides a range of training courses – LOC induction courses, leadership courses etc. for individuals within the sector. These are funded on an annual basis by LOCSU for the benefit of the LOCs.

Communications

LOCSU provides communications and information around important national issues to LOCs along with notices from NHS England and so on. LOCSU is currently relaunching LOC online which is a website platform for LOCs to use to construct their own local websites. This also will provide a formal conduit for information to pass from LOCSU to LOCs.

National Optometry Conference (NOC)

LOCSU organises the annual NOC in partnership with the AOP and tries to ensure that all LOCs participate in debates through the provision of one free place per LOC. This event is the main networking event for LOCs on a national level each year.

25. COVID-19 Addendum

Background

Three weeks before the first draft of the review was due for submission the UK was placed under lockdown. COVID-19 cases and deaths were increasing exponentially, thus creating unprecedented demands on our health system. Community pharmacy was placed at the forefront, as the general population firstly raced to ensure that they had the medication required in case they became infected and then raced to ensure that they had enough of their long-term medication.

Whilst demand for community pharmacy services soared and measures had to be taken to ensure that staff were protected and social distancing was maintained, the government failed to actively name pharmacy staff as key workers, failed to consider pharmacy needs for personal protective equipment or for testing for the condition itself. Latterly was there recognition that the vulnerable would not be able to come to the pharmacy and would need their medicines delivering.

At the start of the COVID-19 crisis an exponential increase in communication within the 'Gaggle group', consisting of COs, LPC chairs, PSNC representatives and others with an interest in LPC activities, was identified. With evidence of duplication of effort, numerous repeated concerns and a need for centralised guidance, a better method of communicating with LPCs was identified as being required by the PSNC executive. Consequently, a Rapid Action Team (RAT) consisting of thirteen Chief Officers from across England was set up with a chair employed to manage the group and its activities on behalf of the PSNC. The group met twice a week virtually with all members and PSNC executive members in attendance. Where appropriate occasional guests were invited e.g. representative from NHS E&I or GPhC as was necessary for the problems being resolved at the time. These meetings were informal with no minutes. Later on in the process agreed 'action points' were routinely recorded. CCA, NPA and AIMp representatives joined the RAT late into the process to enable quicker communication with the contractor representatives.

From the small numbers of emails which the review team received from the PRSC and colleagues in practice during this time it became quickly apparent that LPCs and the PSNC were operating in a new and effective way as a result of the RAT. It was therefore decided to capture the learning from this experience to ensure that the report was current when it finally emerged.

Method

The CEO of PSNC and the chair for the Rapid Action Team were both interviewed.

All 13 members of the Rapid Action Team were then asked to contribute their thoughts in response to the following questions via email:

- What have you learned from participating in this?
- What positive outcomes have come from this?
- What should we change longer term as a result?

The common themes which resulted from the interviews and responses to the questions were summarised.

Results

19 responses were received from RAT members plus COs and LPC chairs from outside of the rapid action team who additionally wanted to comment on the process and experience. The main themes from the interviews and written responses were communication, responsiveness, relationships, perceptions and understanding, effectiveness, resources and future working.

Communication

- Being able to obtain feedback from LPC COs on proposals was very helpful in all PSNC activities from negotiations through to communications with LPCs and contractors.
- The RAT was seen as a better way of transferring information down from the PSNC to LPCs.
- RAT members appreciated the ability to provide feedback on, input into and influence PSNC decision making.
- RAT members appreciated understanding the background/context to negotiations and how the process worked as this informed their communications with contractors.
- Seen as the first regular model of two-way communication between PSNC and LPCs.
- RAT provided a regional go to person who could communicate upwards on behalf of LPCs.
- Having an agreed and shared agenda and list of priorities increased openness between the PSNC and LPC.
- RAT provided a patch to the broken relationship between the PSNC and LPCs.
- RAT ensured that the most important messages were cascaded.
- A top down approach to communication by the PSNC through RAT was noted as still prevailing by some respondents.
- Early sighting [Better communication regarding] of national initiatives before they were introduced allowed LPCs to be better prepared.
- Communication by RAT members to their regions was left to their discretion using the process which were more locally acceptable.
- Internet platforms made it much easier for COs to communicate with each other both regionally and nationally.
- At least one CO reported aligning weekly LPC meetings with RAT meetings to enable more rapid dissemination.
- Quality of communication to contractors from LPCs was believed to be improved as a result.
- Sharing of ideas through better communication across LPCs was believed to result in better designed services and solutions to problems.

Responsiveness

- The ability to access expert advice from LPCs by the PSNC exec with some immediacy was appreciated. COs have protected time for delivery of LPC activities and therefore were available to respond to questions in a timely manner.
- The ability to be able to rapidly and effectively communicate to LPCs without time for misinformation to leak out was seen as central to improving clarity of message.
- The lack of bureaucracy within the model was seen as a reason for its responsiveness.

- The immediacy of information meant that decisions could be made more rapidly at a local level.
- NHSE&I decision making was allegedly slow throughout the process. This then affected PSNC ability to communicate outcomes to contractors. The RAT enabled the frustration with NHSE&I responsiveness to be effectively communicated to contractors thereby removing the blame which would usually be placed with the PSNC.
- Problems such as 'Hot sites' (whereby medical practices were nominated as COVID-19 centres and had community pharmacies located within them) were identified quickly and responded to more rapidly and in a more standardised manner across England as a result of the RAT.

Relationships

- The RAT and its inclusive and informal ways of working improved trust between the LPCs and the PSNC executive. It has reduced the them and us culture which pervaded prior to this.
- The RAT brought COs and the PSNC executive much closer together and more latterly CCA and the NPA.
- Whilst some thought the late inclusion of CCA and NPA representatives in the RAT was a positive outcome others were more sceptical of their motives e.g. not trusting the power that LPCs would have if they worked together effectively.
- The openness/transparency and sharing of information enabled contractor problems to be quickly identified and resolved and for LPCs to better understand the different day to day problems the PSNC was dealing with.
- The RAT resulted in better working relationships, sharing of resources and expertise between LPCs and COs.
- The RAT demonstrated the value of a more formal CO network which is tasked with solving problems and sharing ideas.
- The lack of support for a nationally standardised COVID-19 testing website to be located on some LPC web pages by a small number of LPCs who did not want to be seen to be doing 'what the PSNC asks them to do' demonstrates the need for closer working and better relationships between the two.
- Working together resulted in better recognition of everyone's strengths and therefore who to go to with different problems.

Perceptions and understanding

- Regular virtual meetings with regional representatives, led by a non-London-based individual on behalf of the PSNC seemed to reduce the London centricity perceptions of how the PSNC operates.
- Seeing how the PSNC exec operated and what it had to deal with increased respect and increase recognition of how hard working, knowledgeable and proactive they are.
- A number of respondents reported that they realised how under resourced the PSNC executive team was as a result of this regular communication and closer working relationship.
- The process had made COs realise how proactive and innovative they could be as a group.
- The PSNC got to understand the problems which LPCs face.

- Concerns were raised about the RAT members being inappropriately perceived as senior to other COs as a result of this.

Effectiveness

- The model of bringing LPCs closer to PSNC executive and decision making was ubiquitously seen as effective.
- Duplication has been reduced as a result of shared learning of best practice.
- Model was effective at managing stakeholder needs and expectations.
- Model was effective at managing CO and LPC frustrations, thereby shielding the PSNC.
- It was recognised that effectiveness was dependent on the quality of the chair.
- Due to its effectiveness there was almost unanimous agreement that the model should persist in this format or another and that it should replace the Gaggle group. Numerous ideas for how it should continue were proposed.
- Tangible successes were reported as: supporting protected closures, guidance on compliance aids and care home services, guidance on the delivery service, bank holiday funding, "Hot site" issues, 5F codes.
- The process of working in a network and understanding the national agenda allowed local strategies to be better shaped and informed.

Resources

- Using COs to obtain information and as a network to provide it diminished the need to use PSNC committee member time
- The pressures on the PSNC committee members and their businesses as a result of the pandemic impacted on their ability to provide additional support to the PSNC executive.
- The PSNC had no additional resource or capacity to deal with this. Executive team members were consequently consistently working 12-14 hours a day every day during the crisis.
- Whilst NPA and CCA offered to provide additional resources to support the PSNC executive during this time their ability to help was limited without knowledge of the PSNC systems and specific expertise associated with many of the roles.
- There was agreement that this 'virtual' model of working saved travel costs, time in cars and would result in reduced costs for LPCs.
- It is not possible to pay fees to individuals to attend virtual meetings which don't have travel associated with them and therefore different models for funding such activities are required if virtual meetings are to become more normalised practice.
- RAT to progress to a more proactive / project group to ensure that strategy is in line with operational possibilities and financial positions of contractors.

Future working

- Needs to be more formal to ensure that all concerns and issues are recorded and responded to. Perhaps a 'You said, we did' log
- Needs to have a purpose beyond discussion (which is where it was getting to) if it is was to remain
- Probably needs to meet less frequently in the future
- Longer term work plan required including strategy, goals, KPIs and specific operational considerations to help form a base for LPCs to develop

- RAT members should be selected regionally and role could rotate between COs
- If the RAT continues it needs to be LPC led
- Needs to be a central process whereby LPCs can upload and share materials

In addition to the impact and learning from RAT a number of respondents took the opportunity to describe how the crisis had changed LPC ways of working:

- LPCs being within located multi-disciplinary COVID-19 crisis task groups good for building relationships and these can provide a forum for communicating more directly with NHS E&I
- LPCs individually started working more naturally within STP and ICS footprints
- LPCs regionally starting to work more in alignment with NHS regional structures
- Irrespective of the RAT some LPCs had started to work in a more collegiate manner as a result of COVID-19
- Experience realised the value of the regional LPC network and demonstrated the power of COs working together
- Website use by contractors had increased massively and that these had to be updated a number of times a week

Discussion

The final report, which was largely complete at the time of the mandatory lockdown, was not materially changed as a result of these findings. What these findings have done, however, is provide very strong evidence to support the review's main recommendations.

Recognising the potential efficiency gains, we had already recommended greater reliance on technology for communication and meetings purposes. COVID-19 has accelerated and will possibly cement adoption of these approaches.

The set-up of the RAT by the PSNC which placed LPCs at the centre of the crisis has provided many tangible benefits for contractors, with communication reaching them more rapidly and problems being responded to far more quickly as a result. Sharing of resources and recognising individual strengths within the network has resulted in reduced duplication and variation in practice.

The improvement in communication, relationships and trust has occurred when the current regional network was bypassed. Thus demonstrating the need for a more direct line of communication between the centre and LPCs. Whilst the 'them and us' perception was believed to be diminished by this model, some LPCs, not wishing to seem subservient, still resisted requests from the PSNC.

Discussion

26. Discussion & Conclusion

The process

When embarking on this review it became very apparent we were working within a culture which was not used to external oversight. This was evidenced by the many emails we received questioning the validity and quality of the review, combined with the appropriateness of its speed of delivery. Perhaps of greatest concern was the view that the review team were working to a pre-set hidden agenda. Our agenda has always been to ensure 'value for money for the contractor'. Hopefully in reading the report and our recommendations it becomes apparent that the process was robust, there was sufficient time to undertake it and that no pre-set agenda would have influenced the recommendations we have put before you.

Whilst the system may have seemed resistant to review and oversight, we found that every individual we interacted with either by interviews, focus groups or through LPC visits wanted to do the best by contractors. There was overwhelming positivity and incredible honesty. It was also apparent how hard everyone was working towards this goal and that they had given up their valuable time to support us. Everyone clearly expressed a desire to be part of a system which delivered the best outcomes for contractors and patients and wanted to help us to achieve this. For this we are immensely grateful.

What ultimately motivated us to deliver this review was the potential of a more united community pharmacy network and a much stronger community pharmacy contract providing better value for contractors and ultimately outcomes for patients.

Accepting the relative pace of the review, we were delighted with the amount of information which we gathered and how often there was consensus with respect to what needed to change. In all stages of data collection, we saw that we had reached the point whereby we were no longer learning new things. Looking outside of the system was also incredibly helpful in developing our recommendations. Repeated concerns regarding impact and timings also made us think carefully about how and when our recommendations should be implemented. We recognise however that whilst we have provided this level of detail to justify our recommendations, ultimately it will be up to the PSNC and LPCs to decide whether and how to implement them.

With our original assumption that we would be making recommendations to finesse the system that was in place we are somewhat surprised by the extent and nature of what we are proposing. Whilst far more fundamental and wide ranging than we had envisaged, we believe that all our recommendations are worthy of serious consideration to ensure that the changes truly provide better value for money for the contractor now and in the future.

Governance

Throughout there was clear evidence of innovation emanating from within LPCs and PSNC committee and evidence of executive members working beyond expectations and reasonable working hours. However, a lack of 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. Interviews with PSNC members frequently cited concerns regarding variation in productivity and outputs between LPCs and the fact that there was no governance infrastructure.

The review of LPC websites found that almost one third of LPCs had not posted a financial report in the previous 12 months, with only a very small proportion providing 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. Concerns regarding all of these elements were cited by contractors, contractors should not be expected to vote on LPC membership without such information.

Similarly, there was 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 dissatisfied with the current national contract, which the levy is paid to optimise.

It was therefore very reassuring that over two thirds of LPCs and many of the PSNC members interviews 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 elements of the network, answers to contractors and that it is responsible for development of and monitoring against a governance framework.

A number of elements were recommended for inclusion within any governance framework, including:

- Financial transparency
- Self-certification of compliance
- Availability of committee minutes
- Reports on member engagement
- Annual reports
- AGM for contractors and contractor engagement events with evidence of listening
- Training for committee members and records of completion
- Adherence to human resource policies
- Patient and public involvement
- Support for contractor satisfaction survey (delivered nationally once a year)
- Website quality

Whilst the final standards would be set by the governance body, we suggest that training on topics such as GDPR, equality and diversity should be a requirement, with additional training

in recruitment for those involved in any staff appointments. Training of this nature, or ensuring that it is up to date, 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.

One thing, of which we became aware, was that LPC and PSNC committee members assumed personal liability (or their employer did for them if they are a contractor representative) for any financial mismanagement or litigation which could result from the behaviour of the committee or individual members on its behalf. Consequently, it is important that all risk within the system is minimised. The personal liability element of committee membership also partially explains the need to separate contractors from employees.

We found that in some places the Chair and Chief Officer 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. 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 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 key performance indicators (KPIs) would help to focus activity and reduce variation in practice and performance. Survey respondents suggested that KPIs for LPCs to potentially include evidence of:

- Effective representation
- Supporting implementation of new services
- Improving patient and public view of community pharmacy
- Patient and public involvement in activities
- Supporting development of national templates
- Creation of new contracts with appropriate profit margin within them

On the latter point, the inability to negotiate local contracts with sufficient profit margin within them was commonly cited as creating work with no obvious benefit to contractors. It would therefore seem appropriate for training to be available to LPC COs and Chairs on effective negotiation skills and that no new local services should be set up, unless as a pilot, without a reasonable profit margin. Similarly, with a community pharmacy workforce currently stretched due to reduced national funding, all current local services which don't meet these criteria, should ideally be reviewed.

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 code of conduct for all LPC and PSNC members and again this was supported by PSNC members, LPCs and contractors alike.

The release of the CCA position statement regarding the review, followed by guidance on what CCA believed the response should be to each element of our LPC survey, resulted in a small number of COs and Chairs actively and personally berating their CCA committee members for the views expressed within it. This unfortunately highlighted a bias in Chair and CO attitudes to CCA committee members, not recognising that the CCA levy made up a high proportion of most LPC incomes and that their role is to represent all members equally.

Similarly, when we sought nominations for the program steering committee and for regional focus groups we were informed of some Chairs and COs informing their CCA and AIMp members that they were not allowed to apply as they weren't independent contractors. This surprised us, made us further aware of internal tensions between groups and confirmed concerns that some LPCs still saw themselves as providing services primarily for independent contractors.

Unfortunately, however, some CCA members read verbatim from the CCA guidance documents within both the regional focus groups and in their local LPC meetings to complete our survey. This behaviour did nothing to build relationships within the LPCs. The fact that the contractor representatives are not seen to be voted for, in a similar manner to independent contractors also does not seem to help.

We would like the process for selection of representatives from AIMp and CCA to be more transparent as we understand that there are election processes underpinning this, however this is at the behest of the companies and somewhat outside of the remit of this review. Our primary concern, however, is for the cohesiveness of LPCs. As such we believe that COs and Chairs must give some thought and effort into developing strategies to better balance attitudes towards both sides to better integrate the committees such that differences in employer are not 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 the leadership with respect to this must come from chairs and Chief Officers.

We asked questions regarding diversity and representation within LPCs due to repeated concerns regarding male dominance within LPCs and on the PSNC. 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 or undertake it. Positive action, through the setting of targets for individual groups identified as under-represented within the network, is 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 think this is 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 notion of local pharmaceutical committees, citing the value provided by local support, the provision of a local voice for pharmacy within relevant healthcare and local authority systems and the fact that all community pharmacy service innovations were 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 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, clear recognition throughout the process that efficiency of LPCs could 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 and potentially find additional resources to support any recommendations resulting from this review. 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 the following levy funded activities:

- Local representation
- Initiation and development of locally negotiated services
- Reviewing requests for new contracts
- Providing support for Pharmaceutical Needs Assessments
- Promoting community pharmacy locally and nationally
- Providing regular and effective opportunities to listen to their contractors

Involvement in patient and public members within their processes is also strongly recommended but not listed as an activity as such.

Whilst many LPCs do more than that listed above with their levy funding, there is no consensus with respect to these other activities and some activities are seen as providing preferential treatment to one contractor group over another. To ensure best value for all contractors it is therefore important that LPCs review the current activities they undertake with levy funding to ensure that they are focussed on representation and are not seen to provide preferential support.

Ideally all other activities, which are not listed above and are essentially 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.

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 think 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 Gaggles email group 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 future working.

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, 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 allow 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 paid 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 representatives from 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 don't 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 decision making 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 Team process. 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 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 to 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 large LPCs would not dominate on this basis.

Whilst recognising that all recommendations have been to reduce committee size, this is a Council and would not be expected to operate as a committee as such. 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 centrality within the current system.

With the additional responsibility for Chairs associated with attending and preparing national Council meetings, we propose that they are remunerated to cover the time required to deliver their responsibilities. This however could be partially 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 to 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 appropriate 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 independent governance and strategy body to develop the governance framework and on developing a strategy 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 not 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.

Workforce and training policy is an obvious omission when comparing with the GPC model. One of the main results from the most recent GP contract negotiation was the recognition that the workforce was stretched and there was successful negotiation of additional significant income and support to address this. Within community pharmacy we have still not addressed the fact that there is no funded protected learning time for community pharmacists (seen within hospital and now primary care pharmacy) or the fact that there is no support for the development of support staff. Currently hospital and primary care employers training pharmacy technicians receive salary support.

We therefore propose that the policy groups could possibly consider:

- medicines supply
- clinical services review and development
- workforce and education
- IT systems
- practice finances
- community pharmacy regulation

These are however suggestions only and would be decided as part of the transformation process. Furthermore, the focus of such groups could change depending on the priorities for the negotiations at the time.

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, was 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 and such that the LPC 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 a communications team with a wider remit.

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 was 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 LOCs but found that, due to variation in usage and need, that 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 within the NHS than the voice of a patient representative and 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 agreement that the PSNC exec 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 exec 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 and a team to enable it to be delivered in time for the next significant national contract review in four years' time. Whilst outside of our original remit we have estimated the cost of the recommendations within this report. We actually suspect, that nothing can change until additional resources are allocated directly to the PSNC executive as COVID-19 has pushed it to its limit and beyond.

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 reserve 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 body providing that it was appropriately constituted to ensure that all stakeholders are included within it. The national council would however need to be central to any such process.

New names

The expansion of role, of what was the PSNC, beyond pure negotiation, requires recognition within the name and therefore we propose that the 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 never use the term. Consequently, we believe that as part of the modernisation process this term should be removed from all documentation where possible 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.

Conclusion

This review was initiated at a time when remuneration within the Community Pharmacy contract was at an all-time low. Concurrently demand and need for more clinical services being delivered through community pharmacy was increasing as a result of insufficient capacity within medical practices and increasing patient demands on Accident and Emergency departments. The COVID-19 crisis has demonstrated the importance of community pharmacy for patients and the quality of profession in its response in the adverse circumstances. The repeated delay in Government recognition of the contribution made by community pharmacy throughout the crisis unfortunately however, highlighted its low standing in the national consciousness. The need for both one voice from community pharmacy and an effective national communication strategy were clearly demonstrated.

The review itself found relatively low levels of satisfaction by contractors with their LPCs and the PSNC. The PSNC is largely measured by its negotiation outcomes, for which there was almost unanimous agreement that they could be significantly improved. Professionalising the negotiating team and better planning for the process was recommended on a number of occasions.

LPCs were measured by their transparency, the income derived from local services and their ability to both communicate with and listen to contractor voices. Whilst a number of LPCs were seen as shining lights with respect to these practices, evidence from the survey and website reviews demonstrated that this was not so for all LPCs. There was broad agreement that an overarching governance body and framework should improve performance across the whole network.

The review quickly found that the relationship between LPCs and PSNC could be significantly improved. As a result, the PSNC has worked with the same budget for five years as it felt unable to request additional funds from LPCs. Similarly, without effective central co-ordination, LPCs were largely working in isolation, resulting in significant variations in practice and duplication of effort. The fragmented network therefore has the potential to provide significantly better value for money for contractors.

This was all evidenced through the COVID-19 results whereby the PSNC executive was found to be significantly under resourced to respond to the crisis and the implementation of a direct and regular line of communication with LPCs greatly enhanced effectiveness and trust between the two. The development of a CO network immediately improved communication at all levels and greater sharing of resources. Whilst the new model of working clearly improved satisfaction with the PSNC executive, a mistrust of the PSNC still existed and desire not to be directed by the PSNC was still expressed by some LPCs. A more encompassing model, whereby LPCs are the centre of the national process, rather than on the outside with a small group of representatives on the inside, was demonstrated to be required.

The General Practitioner Committee (GPC) constitution and Community Pharmacy Scotland, locate their local committees at the centre of the national negotiation process and both models have proved to be effective. Similarly, the GPC employs, extensively trains and supports their negotiating team. We strongly recommend therefore that the current PSNC committee are replaced with a national LPC council and that all policies relating to negotiations are derived from this group. To improve efficiency and enable more resources

to be centralised for the purposes of the national negotiations and provision of centralised LPC support, LPCs should consider the number of contractors they represent, the size of their committees and the use internet of platforms for communication, meetings and training purposes.

Whilst we have made a raft of recommendations we propose that there are three which require immediate consideration and if these are constituted then the remainder can be decided within the new framework.

Firstly, it is most important for contractors that the national negotiation process is immediately optimised and consequently additional funds for the PSNC executive and a national Negotiating team are released for this purpose. We have estimated the cost of implementing all recommendations and suggest that increasing support for the PSNC CEO, setting up the Negotiating Team and the governance and strategy board would cost between £6 and £10k per LPC on average. The cost of implementing all recommendations estimated to be between £20 and £33K per LPC. We recommend that additional funds should be sought from appropriate external sources wherever possible and appropriate.

Secondly, we recommend that the independent governance and strategy body (CPE board) is constituted and set up to develop and implement a national governance framework for implementation across the whole network plus support implementation of new initiatives at a national level.

Thirdly the national council for LPC chairs should be constituted (to initially run alongside the PSNC) to discuss and agree which recommendations from the review should be taken forward and how this should be best achieved. This council would be able to vote on negotiation outcomes on behalf of all contractors similar to that seen within the current General Practice model.

Once the independent governance body and national council are set up then they should work together to develop one voice and a national strategy for community pharmacy.

To manage the process, we recommend that an implementation plan is developed. The current and newly appointed independent chair of PSNC should lead the work on this. In doing so, she would need to ensure that all stakeholders are appropriately represented.

27. Estimated additional costs associated with recommendations

Below is a very rough estimate of what the recommendations within this report could potentially cost from the perspective of LPCs. What were adopted and the grade of employees would be decided by the CPEC and overarching governance body.

Underpinning assumptions

- With much greater working from home anticipated as a result of COVID-19 then the PSNC office would not need to expand to accommodate new appointments
- Cost of CPEC meetings per year (two virtual and two face to face) same as current costs for LPC conference.
- Costs for CPEC member time similar to current PSNC member costs.

Average salary estimates including overheads

- Senior manager salary with professional expertise £130k
- Senior manager salary non-professional £100k
- Professional employee salary £80k
- Non-professional employee salary £70k
- Senior administrator salary £40k
- Administrator salary £30k

Costs

What	Max cost	(Min cost)
Negotiating Team		
• 1.6 FTE (4x 0.4FTE Senior Pharmacists)	£208,000	£208,000
• Senior administrator (0.4 FTE)	£16,000	£16,000
• Travel and training budget	£40,000	£40,000
Secretariat to support CEO		
• Four (two) non-professional employees	£280,000	£140,000
Policy group directorates support		
Assume some current internal staff may be transferred to these		
• Four(two) senior managers with professional expertise	£520,000	£260,000
• 2.4 FTE (6x0.4 FTE) administrators	£150,000	£150,000
Governance and strategy committee (Virtual meetings)		
• Two (Zero) Non Executive Members	£40,000	£00,000
Sub-total	£1,176,000	£736,000

Additional centralised CPE & CPL support services

What	Max cost	(Min cost)
HR Department		
• One (one) Senior manager	£100,000	£100,000
• Two (one) employees	£140,000	£70,000
• One senior (non-senior) administrator	£40,000	£30,000
• Consumables and travel budget	£10,000	£10,000
Comms team expansion		
• Two (One) additional full time member of staff	£100,000	£100,000
• One senior (non-senior) administrator	£40,000	£30,000
• Budget	£250,000	£150,000
Finance support team		
• One (one) Senior manager	£130,000	£130,000
• Two (one) employees	£140,000	£70,000
• One senior (non-senior) administrator	£40,000	£30,000
• Consumables and travel budget	£10,000	£10,000
Sub-total (Centralised support services)	£1,070,000	£700,000
Total	£2,246,000	£1,436,000
Average cost per LPC per year	£32,550	£20,880

Externally Sought Funding

Transformation budget (3 years)

• Manager/lead	£390,000
• CO/Chair/PSNC member support	£150,000
• Administrator	£120,000

Community Pharmacy Integration Centre (cost per year)

• Manager/Lead	£130,000
• 3 x FTE research staff (e.g, Health economist, Statistician, Implementation scientist)	£300,000
• Administrator	£40,000
• Travel/consumables	£10,000
• Budget to support pilots (5 per year) through CPLs	£300,000
• Budget to support one major trial of a new service	£250,000

NB: Five-year budget would be required

Glossary of terms

28. Glossary of terms and acronyms

AIMp	Association of Independent Multiple Pharmacies
APTUK	Association of Pharmacy Technicians UK
BMA	British Medical Association
CCA	Company Chemist's Association
CPE	Community Pharmacy England
CPEC	Community Pharmacy England Council
CPW	Community Pharmacy Wales
CPS	Community Pharmacy Scotland
Contractor	Individual or body which holds community pharmacy contracts
Contract representative	Individual nominated by employer to represent community pharmacy contract or contracts
CPL	Community Pharmacy 'Local geographical name'
GPC	General Practitioners' Committee
LOCSU	Local Optical Committee Support Unit
LPC	Local Pharmaceutical Committee
NPA	National Pharmacy Association
NSC	Negotiation strategy committee
NT	Negotiating team
PDA	Pharmacist Defence Association
PSNC	Pharmaceutical Services Negotiating Committee
RPS	Royal Pharmaceutical Society

Appendices

29. List of appendices (On-line only)

- i. PSNC model job specification for Chief (Executive) Officer (1)
- ii. LPC constitution (2)
- iii. LPC governance guide (3)
- iv. PSNC rules effective (4)
- v. PSNC structure (5)
- vi. PSNC constitution (6)
- vii. CCA position statement (7)
- viii. NPA position statement (8)
- ix. AIM position statement (9)
- x. RPS position statement (10)
- xi. LPC and Contractor focus group topic guides (11)
- xii. LPC survey tool (12)
- xiii. Contractor survey tool (13)
- xiv. Contractor national survey data analysis (14)
- xv. LPC national survey data analysis (15)
- xvi. Independent review team (16)

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