Pharmacy Review Steering Committee (PRSC) Minutes

5th March 2020

Attendees and role

David Wright, Independent Chair (UEA, Norwich) [DW]

Shilpa Shah, LPC Representative (LPC Executive Officer representative) [SS]

Ruth Buchan, LPC Representative (LPC Executive Officer representative) [RB]

David Bearman, LPC Representative (LPC member representative) [DB]

Vicki Roberts, LPC Representative (LPC member representative) [VR]

Mark Ireland, Contractor Representative (CCA) [MI]

Adrian Price, Contractor Representative (CCA) [AP]

Reena Barai, Contractor Representative (Independent) [RBa]

Asif Alidina, Contractor Representative (Independent) [AA]

Peter Cattee, Contractor Representative (non-CCA multiple) [PC]

Simon Dukes, PSNC Representative (CEO PSNC) [SD]

Richard Whittington, LOC representative (CEO LOCSU) [RW]

Michael Twigg, Pharmacy Review Team (UEA, Norwich) [MT]

Zoe Long, Observer (Director of Communications and Public Affairs at PSNC) [ZL]

Bethany Atkins, Administrator (UEA, Norwich) [BA]

Minutes and Actions

Welcome and introductions

The committee were welcomed by the chair.

In addition to the nominated and selected members, Dr Michael Twigg was present, who is a part of the Pharmacy Review team and based at the University of East Anglia.

1) Minutes from 23rd January (Accuracy)

The PRSC discussed the draft minutes from the previous PRSC meeting on the 23/01/2020 and made the following comments and recommendations:

- Typo bottom of page 2
- 5th paragraph section 3 - 'DW noted…' should read allay not relay
- VR page 5 incorrectly states that Adrian set up a provider company. AP clarified that a collection of representatives across NPA and PSNC set up a provider company.
- RB noted that it is not 'my LPC' on page 8 but LPCs generally and to remove 'her' to 'some' to more accurately reflect her comment
- SS and RB asked to change their titles to 'Chief Executive Officer'
- VR suggested adding all initials to the first page of the minutes.

There was agreement from the PRSC to publish the minutes on the website.

ACTION BA: Make above changes to the minutes and add to the Pharmacy Review website.

2) Statements from the chair

DW updated the committee on the PSNC member and employer interviews.

He stated that he had interviewed five PSNC employees, including Simon Dukes and Sue Killen. DW noted that the interviews have corroborated what a lot of people have said re: the PSNC being overworked. The PSNC have lots of good ideas of how to add value to the system but no resources or headspace. From this he noted that it seems there needs to be more resources at the center.

DW has done a GPC interview and has sent an email to GDC with questions he would like to be answered. He noted, however, that it has gone quiet and there has been no response.

DW noted that the one thing that had stuck in his mind from the GPC interview was the makeup and operation of the negotiating team. He explained that there is a two-day interview schedule and the chair selects the members they want. They then go on intense negotiation skills training, leadership and management, media, and equality and diversity training. Only then do they take on the role of negotiator. DW noted that what was also interesting is how the team worked together and the mix of personalities. DW stated that the GPC negotiating team as a model works and has been effective, and it should not come as a surprise that the thinks that the PSNC will need to do something different with their negotiating team and how it is put together in the future. This will come through in the recommendations in the final report.

AP stated that this is exactly what they do with their buyers.

DW asked so why aren't we doing it?

PC stated that he is on the negotiating team and fundamentally the position of the PSNC is more complex than people just buying 'stuff'. Agreement that it should be changed but it's an overly simple analogy. He notes unity of purpose is important.

DW noted that there are some tensions in the system that the GPC don't have and he recognises that, and it is how PSNC get that unity of purpose that is important.

SD stated that we have a very different sector – independents, multiples and everything in between and the GPC do not have that.

Twenty PSNC member interviews have been undertaken to date between DW and MT.

The majority of members believe that the PSNC committee is too big. There is recognition that the PSNC does not have all the skills it needs and they need to try to bring in people from outside. DW picked up a lot of mistrust between different PSNC members (independents and CCA) and they also recognise that the negotiation team has conflict as well. Many commented on the documentation they receive from the PSNC. Notably, many felt that the PSNC communicates only after it has already made decisions, the information provided to the committee can be too high level and not communicated in a readable consecutive summary. There was largely agreement regarding limiting the terms of service. DW noted that the GPC model is currently two 3 year terms which is a standard corporate model and that they are planning to move to a 12 year model to allow people to make more contributions. Many also agreed that there is a lot of duplication in the PSNC team and there needs to be better communication between the PSNC and LPCs. DW noted that nothing surprising had come out of the interviews but a lot to support that there needs to be changes from where the PSNC are now.

MT added that what was striking in the interviews was the lack of trust that then influences how the committees operate.

MI asked what they think is the cause of that?

MT stated that for him it linked to the context in which community pharmacy now operates and the complexity and amount of information. People can't be across absolutely

everything and therefore need to be in the room to hear those discussions because they can't engage with all of the material that comes out of that.

PC noted that to illustrate why there is benefit to people being on the PSNC for a considerable period of time to remember community pharmacy has been under the economic hammer for many years – pressure to beat government efficiency savings consistently, NHS promising increases and not delivering. He noted that community pharmacy has been under that economic stricture for longer than people appreciate and the consequence is an economic envelope in which the only way to succeed is at the expense of other people. That is the conflict and why people find it difficult to trust each other, inadvertently contractors been have been pitted against each other in some regard.

RB stated that is isn't just about better comms between PSNC and LPC – it's actually division of roles as well as the comms.

SS agreed – a job profile of what the PSNC will deal with and what the LPCs need to take care of, otherwise you could be waiting for comms that never come.

RBa stated that if people are on the committee too long it blocks talent and that not enough is done with succession planning, some people who are in those positions are also not on the ground seeing what it is actually like, so there's a disconnect and it feels like this has come through on the surveys

MT noted that the interviews also highlighted concerns re: succession planning and who will be replacing the people retiring

RBa noted there is a problem with 'stayputitism'

In response to how long people have been there and the 'distance' between PSNC members and those on the ground in community pharmacy, RB stated that isn't the case for everyone and it's about transparency

RBa noted that while yes there is that balance, it doesn't mean that one person has to stay on for a long period, we need a balance of new and old and at the moment it feels very old

DW noted that the GPC does not remove members for life, but people have breaks before coming back to allow other people to contribute.

DW stated that the problem is with 31 members it's difficult to build those trusting relationships and get to know all of them.

MI highlighted the way that the NHS manages non-executive director roles and pathways.

PC noted that he agrees with the succession planning but he hears the coal face thing a lot as well. It's looking round the AIM members in particular – the coal face hasn't changed that much and I worked there 5 days a week for 25 years

DB noted that re: local vs. centre – it's not about the issue of money between LPCs and PSNC but whether to survive with existing contract or be expansionist and seek new revenue

DW stated that he has picked up that local negotiations and contracts are sometimes not that great, unrealistic with no profit margin. With the current situation of where there is no money in the system it is not helpful to contractors to give them extra services to deliver which make no profit. The NHS accepted a 15% profit margin when purchasing services.

RB noted that if we apply this to existing contracts – EHC, stop smoking services – if we apply this across standard public health stuff where there is no profit, we may lose local contracts.

PC noted that those services have been cross funded by generic margin forever. Agree with DW in theory but in reality, if you put too much money over [from supply to clinical] too quickly you run the risk that collapse the core service [supply].

SS stated that we all need training on good negotiation – how do we all (CCA and independents etc.) work together?

RB and united voice so we're not picked off.

DW stated that there are 10 more PSNC interviews to go but that this needed double checking to ensure that everyone has been included.

ACTION ZL/DW: check that all PSNC interviews are organised and everyone included

LPC visits

DW stated that he and MT have visited a number of LPCs – London, Durham, North Yorkshire, Manchester, Norfolk and Suffolk and Somerset. London and Milton Keynes are left to do.

Members in Durham asked DW to put his background into the report as they felt this would help them better understand his perspective, which is why it is now a section in the report.

SS noted that there is a lot of apathy at the moment and no clear structure within an LPC. Each LPC works differently. Everyone knows that they are a member but not what their role as a member is. There should be terms for people – are you still passionate? excited? Do we all work at the pace that the profession now requires?

PC stated that in the AIM company groups and larger multiples you'll bypass it - you'll take the culture, the action and the drive and just go around the outside of the LPC. Nobody wants to leave independents behind but this is a fundamental part of the problem

SS and that doesn't help community pharmacy.

RB stated that re: working at pace, that isn't the case everywhere.

AP asked DW if he attended any daytime meetings.

DW stated that only Yorkshire was daytime. He asked if night meetings were appropriate from an equality and diversity perspective i.e. they would dissuade those with families and children from attending.

MT visited Somerset, Manchester and Norfolk and Suffolk LPCs. He noted that he saw three different models of operating an LPC within these four LPCs, all working to varying degrees of success.

Somerset LPC – MT noted that it was a very interesting day. They are a committee that are relatively enthusiastic and dynamic, but what was frustrating and this was partly due to his academic background, was the services they were talking about implementing. Lots of local innovation and ideas but what is the evidence base for this? He came away feeling positive about community pharmacy in Somerset but as a researcher and academic left feeling frustrated.

MT also noted that it was unclear as an observer if it is the Chair or Chief Officer running the meetings. It also became apparent that committee members were being asking to do things on top of their normal day job, like PCN lead or service development lead, and it seems they are doing this in their own time. VR noted that she sits on West Yorkshire, Coventry, South Staffs LPCs and her role as a committee member on all three is very different. This is a privileged position and when you don't have the benefit of insight from other LPCs it's difficult.

RBa noted that the non-contractor role needs to be forced on LPCs, like an academic pharmacist, 'pilotitis' again is a massive problem in pharmacy and we need to see committees as bigger pictures.

MI stated that the contractor base is incredibly stressed at the moment. Any challenge or push back against enthusiasm is seen as negative and stalling. Just as dangerous to have enthusiasm as to have lethargy, they're causing the same level of problem.

MT noted that as an outsider going in, he could understand the lack of engagement to a certain extent, as there were so many services being discussed – where does someone start? There is so much information.

PC noted that you can ask what does 'good' look like for an LPC, but important is what does 'success' look like?

DW stated that once KPIs are in place, this will change focus and behaviours and also chair training and their responsibilities need to be clear.

Manchester LPC – Manchester recently combined six LPCs (one voted not to merge with Greater Manchester LPC). MT noted that it operates very differently – lots of roles. It appears that their Chief Officer and Chair are the same person. It seems they felt they needed to be larger because of a lack of support from PSNC, also comms were long and wordy. Clarifying roles and responsibilities will help LPCs and PSNC going forward. They have set up their provider company and contracts for services and also the remit to negotiate their own services – does this not do the LPC out of a job? There was not an answer to this.

RBa asked if that was something to do with the constitution, that LPCs can't deal with contracts?

MT noted that provider companies are set up purely as contracting organisations but then those provider companies are then being giving additional roles. DW stated that he understood that North East London provider company had additionally assumed a buying role to get a better deal for contractors.

SD did you ask about the LPC and provider company relationship re: governance?

MT noted that he asked specific questions about the overlap between the two, monitoring, governance structures, responses were quite wooly. SD offered to send MT the work the PSNC have done through CCA and AIM with guidance on setting up a provider company

DB noted that to clarify, Somerset have not set up a provider company yet, they are using the PSNC model and are looking to establish this at a regional level with other LPCs to operate and manage contracts

MI noted that it is badly understood that an LPC is a representative body and provider companies are a separate commercial entity, whether anyone participates in that entity is a commercial decision that is completely separate to participation in the LPC. Time and effort is invested into LPCs and not into provider companies and this is a massive disconnect.

PC noted that he agreed with this statement, but they do want to be involved in provider companies and they could be used to bring contractors together more effectively than PCNs but business interests become intertwined, but for contractors to go down that journey and not know what's happening is unacceptable.

MI feels people do not understand this and that people are working outside their areas of competency.

SD noted that Greater Manchester is the biggest LPC and asked DW if he got a sense of scale, is there such a thing as an LPC that is too big?

MT stated that it is difficult to capture whether it was distinctly different to other (smaller) LPCs, they had more roles and were in the process of taking on more people – director of strategy, director of pharmacy transformation, director of services and director of education. What he did get a sense of was the feeling that because they are now representing a significant number of contractors, that enabled them to think strategically and engage with Greater Manchester health organisations and local authorities on a more effective level.

RB invited MT and DW to a West Yorkshire LPC meeting and offered to provide any information that may be useful, as it is a larger LPC (second largest) that has been around for a longer period and it does not have a provider company.

MT emphasised that Greater Manchester LPC recognised that they are in a very early stage of this process and are finding their feet.

PC asked MT if he had any sense of connectivity between Manchester LPC and PCNs?

MT said that he got no sense of the connectivity apart from them having their named PCN lead for each of the areas, at the moment it's all about setting up the central organisation.

MT gave an overview of his Norfolk and Suffolk LPC visits. He noted that Norfolk and Suffolk have not merged but to a certain extent federated some of their services and share some officer roles. He spoke to both Chief Officers separately and there was a recognition between them that both of them didn't need to employ a communications officer, both of them didn't need to employ somebody to do pharmacy services etc. It was more how it had naturally evolved – sharing people and infrastructure. He got the sense they were concerned about geography and they work closely with Cambridgeshire and were concerned about going too large in rural counties, but in terms of operation they are relatively lean. They tend to meet after training events they are already present for, there is no physical infrastructure. Norfolk has just over 100 and Suffolk has slightly more contractors. He noted that they are mindful of geography in terms of how they operate their LPCs (in terms of commuting) and are reluctant to merge formally. The East of England have an electronic medicines optimisation – there's no funding but it's a service that's been commissioned. Services designed in Norfolk and Suffolk independently were a lot more streamlined (e.g. Emergency Supply Service) and now it has been replaced with lots of paperwork.

3) Local Optical Council (RW)

RW gave an overview of LOCSU. He noted that there are many parallels between LPCs and LOCs, but contextually there is a slight difference around the NHS at the moment: their focus in on PCNs, whereas for LOCs they are irrelevant. The focus of LOCs is Integrated Care Systems and the level above.

The provider company is a very important part of what LOCSU does, but it's not the focus. The focus is LOCs and the role of LOCs in an evolving NHS – where LOCs operate and increasingly where the primary eye care company operates.

The question in the previous minutes says that RW set up a primary eye care company, which is not true. What happened was a number of local primary eye care companies were established, the best part of 10 years ago, and when LOCSU first started a couple of years ago there was a recognition that what the NHS would look away from contracting individual practices and would want some kind of umbrella that sits across the top of them. At that point, the NHS were in the midst of a localism agenda, so a decision was made that what LOCSU would do is form a primary eye care company for every LOC, in exactly the same way, but hold it on the shelf and it would be used when it needed to be used. Those companies were constructed identically, they are companies limited by guarantee and they are technically membership organisations but there is only one member: LOCSU. The directors of the companies are appointed locally by the LOCs and there is an MOU that exists between the LOC and the primary eye care company which says that the directors are appointed locally by the LOC, the company is there to act in the best interest of the LOC, so the LOC do control the company, but there is an overarching control by LOCSU and their role is mainly governance. There companies are free to evolve under the guidance of their LOC but if at any point the company and/or the LOC were not operating in the best interests

of the local opticians they could come to LOCSU and they could act as the ultimate governance arbiter.

This rolled forward for a period of time but what they started to see was the bringing together of primary eye care companies.

RW noted that he was formerly director of commissioning for South East London CCG and then took on commissioning across a patch.

He noted that there was and is no reason why a minor eye condition service in Newquay should look any different to that in Newcastle or that in Lincoln, etc. Optical services are not predicated on things such as demographics and while social conditions do play a role in who accesses the services, the actual mechanism for operating the services is identical. What RW started to see were groups of CCGs coming together to commission a single service, which in SE London for example would incorporate two LOCs, which in theory incorporated two primary eye care companies, and RW noted that he was not prepared to contract two primary eye care companies. He started to see the natural coming together of primary eye care companies, starting in London – 32 CCGs, 12 primary eye care companies in theory.

What RW identified when he arrived was that while the primary eye care company model was the right structure, the NHS was moving away from localism and towards centralism. What also started to emerge was procurement in a proper sense – CCGs were going to primary eye care companies and asking if they could pilot primary eye care services. RW noted that he wanted to bring them all together because they are all fundamentally the same and what he wanted to do in any single procurement was lever the experience and advantage of everything together. A bigger company is able to be both local and national and this is where LOCSU sits in – the governance process, the governance structures, the ways in which they operate, all the processes they operate, they produce on behalf of the LOCs and primary eye care companies. This is where LOCSU are currently and the NHS like it, but RW does think that when you have an LOC that has it's own small private primary eye company they are very invested in it, and as soon as it becomes a big company it does seem a little bit more remote – you have to get the communication right.

You have the associate model within the NHS which means that if you have a single organisation that is delivering a primary eye care service effectively across the country, it breaks down the barriers (e.g. if you don't live in London, but work in London, you will likely access an eye care service in London). In the old world, this would not be possible. Now it's a single entity and you have an associate model that runs across. In this sense, you can truly commission patient-centered services. He noted that there is no point commissioning patient-centered services is the boundary is your borough.

As the primary eye care company has got bigger, RW has sought to put separation between LOCSU and primary eye care company because there is a risk they look like the same organisation, which they are not. They maintain separation because if there is a governance issue this needs to be sorted out independently as opposed to a part of. This is an ongoing and evolving process.

The focus of LOCSU now is very much about the LOCs. Where does the role of the LOC end and the role of a primary eye care company start? A primary eye care company is not there to generate its own business – it does by definition but it's the LOC role to represent to local providers and contractors in discussions with the NHS. LOCs support local providers and LOCSU runs training courses to facilitate this. LOCSU produce all the clinical pathways that sit behind these companies (they are contractor derived because they pay LOCSU to do it).

LOCSU want LOCs and primary eye care companies to use the core pathways because then the services are the same, and it makes merging easier which inevitably will happen in Integrated Care Systems.

LOCSU have three parent organisations – ABDO, FODO, and AOP.

The way RW sees the long-term plan, which pre-December was not much more than a lot of 'we would like to' dos, has now become the blueprint of exactly what they are going to do, which is why everyone really needs to read it and understand it. It talks about the removal of procurement, etc. and RW believes that, since there are going to be seven NHS regions, it's not too much of a logical jump to realise there might well be seven Integrated Care Systems. The primary care networks are hot houses of ideas, the PCNs will generate the ideas, and these ideas will go up to the ICS and be commissioned there, and RW urges everyone to keep their commissioning at that level because that's where you get consistency.

There is an overarching project happening in the NHS at the moment which is the out-patient trust management programme – a multi-specialty programme. The Department of Health are looking for a 30% reduction in all out-patient activity – no one has got anywhere near this before. What this means for LOCSU is two million appointments currently delivered by the Department of Ophthalmology need to be delivered somewhere else and there is a fight on where this will be. RW noted that it has got to be primary care. If LOCSU are successful and that activity moves out into primary care, LOCSU has a challenge and it has potential to change the business model which means you have to bring in discussions around the core contract which have always been kept completely separate.

Questions from previous PRSC meeting:

1. If you were doing it again, what would it look like?

RW: National [Provider company] from day one.

2. When 80% of share is dominated by Specsavers and a couple of contractors – what impact does this have on LOCSU and engagement?

RW: Specsavers is the biggest individual model and in terms of overall revenue give more money, but in terms of their percentage of individual businesses it is exactly the same. They are all equal members of the LOC.

4) LPC survey initial findings (MT)

MT gave an overview of the response process/findings:

- 68/69 responded (one more came in via e-mail as they were unable to submit via the system). Gateshead and South Tyneside was the only LPC not to respond.
- Most committees reported a process for gathering views from the committee and reported the number of people (and affiliation) that managed to feed into their response. Most committees discussed disseminating the CCA, AIM and NPA position statements for transparency to all committee members along with the survey.
- Some really lengthy responses to some of the questions that contained lots of detail and caveats.
- Where there was disagreement between particular views on the committee, this was referenced and the various viewpoints explained.
- MT's over-arching comment is that there is a perception of conflicting viewpoints between CCA, AIM and independents. His view is that while these differences are definitely present, there is much greater overlap of views than he was expecting. There are subtle differences but the main message from both is largely the same.
- MT thinks the main message from him is that change for BOTH organisations is needed now in order to ensure the survival of community pharmacy and make the sector fit for the future.
- In terms of implementation of recommendations, the results highlight some indication of the thoughts of the various LPCs but this was less in-depth than all the other responses (on the whole). The only general consensus was that everybody need to see the recommendations before any decision is made, any decision needs to be decided jointly by PSNC and LPCs and finally, the confirmation/acceptance of recommendations needs to be put to some sort of contractor vote (as the people who pay for both organisations).

DW added that he had received five emails from LPCs upset by what had happened in the LPC meetings. The CCA had given their members a confidential document outlining their position statement and how to answer the survey/focus group questions. DW called Malcolm Harrison to address this – he said that it was distributed so members were aware of the company statement. What MT witnessed was a number of responses that said 'this is what the CCA said, and this is what the committee thought excluding the CCA.' DW noted that this has negatively impacted the relationships between the CCA members on those committees. DW read the governance documents on the committees, and it says quite clearly that while they are representing their employer, they make decisions to the benefit of all contractors. DW noted that this is what Malcolm also said, but it is not what happened in reality.

RB noted that she had got similar feedback, however for some LPCs it was positive and there was not a lot of discontent/split, and was more 'what is best for our contractors in the room?'

MT noted that many responses split CCA, AIM and Independents views. At this point in the data analysis it is not clear yet how these splits were formulated (i.e. if there were meetings and discussions, etc.)

SS also noted that she felt confident her LPC had the views of different groups, but then as a committee decided what was going onto the form.

MT noted that voting pattern was added into the open-ended questions in a significant number of responses, which indicates some dissent within the committee.

RB noted that there was some chat on the Chief Officer's group about how they were going to record responses – e.g. if an LPC had a 2/3 majority that is the view that would be recorded, if less than this the different opinions would be recorded. RB noted therefore that the differences/split between opinions could also be interpreted as them being transparent and helpful rather than being about dissent.

AP noted that CCA are there to inform, not dictate.

MT noted that what was apparent in a few of the focus groups that some people clearly had a position (CCA document) but then were flexible within the discussion, but others did not deter from the document (some read off the position statement in the focus groups).

MT and DW asked the PRSC what they thought the main messages were from the data.

SD: in terms of numbers of responses, London is heavily represented, and there are particular issues and challenges for community pharmacy in London, so how do you weigh against that? There are a lot of community pharmacies in London and it does suffer from not having the services, and those contractors/LPCs will have a particular view because they are LDN. How will the review team deal with that? MT agreed there are a disproportionate number of LPCs that will have filled in the survey that actually just represent London, which means it might skew the results. Agreement to address this question later as it relates to the contractor survey.

The main messages from the PRSC discussion regarding the LPC survey were as follows:

- Responses were quite predictable
- Responses highlight the gap between LPCs and PSNC. More than this, there are various organisations and it is unclear what role they have/serve and the report is a good opportunity to look at the big picture and make roles very clear
- Split of responses into CCA/AIM/Independents is not necessarily a dissenting committee, but about transparency
- CCA view was there to inform not dictate
- Responses highlight the need for a single voice for pharmacy. MT noted that the data suggests that people aren't sure if the PSNC is the organisation to do that – they should play a role but should they lead that? RW noted that this is identical in regards to LOCs/the ophthalmology sector in that individual components can't agree what the single voice looks like.

RE: governance. RB stated that in regards to fixed-terms, need to recognise that long standing LPC members may be a valuable LPC asset

DW also noted that what shocked him with the current governance structures is that bad behaviours are dealt with by the Chair, but some of the bad behaviours *are* the Chair. The risk to LPC committee members – they could be bullied, harassed and have nowhere to go – is unacceptable.

MT added that q34: 'should there be a code of conduct?' is one of the responses that was 100% yes.

DW stated that a working group that is set up jointly between LPCs and PSNC will be a recommendation in the final report, and will include KPIs and measures to ensure good governance.

12.30 – Break for lunch

5) Continuing LOCSU discussion (RW)

Re: the negotiating team at LOCSU.

LOCSU negotiating team refers only to the sight test. The negotiating team for GOS is a committee team called OFNC (Optical Fees Negotiating Committee) and this is made up of representatives from AOP, FODO and ABDO.

AOP (Association of Optometrists) – in effect a trade body for optometrists

ABDO (Association of British Dispensing Opticians) – trade body for dispensing opticians

FODO (Federation of (Ophthalmic and Dispensing) Opticians) – representative body largely for big employers, talk on behalf or for Specsavers etc.

OFNC is also made up of some observers, including LOCSU, BMA and some other organisations. They negotiate the sight test fee on an annual basis, and all of the other services that are commissioned alongside the sight test, e.g. minor eye condition services, are commissioned by CCGs are they are locally negotiated by the LOCs (in theory). It's a joint effort – LOCs start the conversation about what the services will look like, what they are going to be paid, etc. However, the advantage of having a bigger primary eye care company come in is that they understand what needs to be delivered in re: to the bottom line.

For extended services, there is no tariff. No national fee. An identical service in Manchester could be charged at £20 more than exactly the same service in Devon. LOCSU are working at the moment to try and level this out.

LOCSU is the LOC support unit, it's a self-contained title with a limitless remit.

PC asked if in the non-tariff services there is head room for people to develop those?

RW stated that there is, although there is a downward pressure on fees. The profit margins are reducing, there are fewer commissioners as CCGs start to merge and those fewer commissioners talk to each other, so everyone knows who has paid what. The sight test itself is decreasing in profit because it's so open to automation. To build a business today around sight testing is a massive risk, whereas a more medical model (glaucoma etc.) which stop patients going *into* hospital, there's a bit of money. But the actual win is at the back end, the legion of patients that are sitting in hospital with Glaucoma, or undiagnosed, that is millions of people.

PC asked if fashion effectively becomes the thing that muddies the water?

RW stated that this is kind of the case. Traditionally you would have had the high end independents seeing fewer patients but selling frames at a larger cost, and the multiples largely speaking selling cheaper frames but at a higher volume. This held relatively firm until about five years ago. Seeing a Primark effect = people are much more interested in experiences. Traditional market is being squeezed, spending less per frame to get more looks, and this is the rise of the Internet. You can get a quality sight test, take your prescription and go online and buy the cheaper frames.

DW noted that when he has finished writing up the GPC description, he will send it to RW so that he can create a similar one for LOCSU.

ACTION DW: Send RW GPC description

RW said he felt the unintended consequences of PCNs will sink them. The downside of PCNs is that they will destroy elements of a universal service. Sub-contracting is a big opportunity

DB asked in terms of LOCSU's provider company, some of these services will be multidisciplinary so why wouldn't we look at a primary care provider company?

RW agreed. There needs to be a single mechanism where you have a primary care company, but that is also what an ICS is. ICS's are about the bringing together of all the deliveries of care in that particular geography. PCNs are the complete opposite – the whole direction is regional and it's push up. They are a red herring, it's simply about pumping money into GP Practices. PCNs are replicating that process and will be subsumed by the ICSs. Cambridge is a good example – they are federating PCNs already.

DW noted that it seems it would be a good idea to recommend a national provider company. Why would it work now when it didn't work last time?

MI noted that it is about timing, structure, and expertise. However, he is still not sure as we have an established market where we have 60-100 million locally commissioned services just happening. Do you need this perpetuated going forward?

DW noted that there are obviously economies of scale and good reasons to not allow it to be done locally. A recommendation could be to work towards setting up a national provider company?

DB at scale, whether that's regional or national.

RBa with clear governance.

RW asked if all current local Provider Companies are structured in the same way?

PRSC agreement that they are all very different.

RW noted that getting everybody into one company is going to be hard, especially if they're structured in different ways.

RBa noted that there are not many that are working well, and those that are working well and may like to remain separate and not join a national company.

6) Views from the bridge (Round table discussion)

RB stated that since the review closed, she hasn't heard anything about it and she thinks people are moving on. VR similarly noted that there was a lot of noise during the month because of PQS happening at the same time but it has since quietened.

VR noted that a couple of provider companies over the past couple of weeks are looking to fold.

SD stated that PSNC members may be talking amongst themselves but he has not heard anything. There is an understanding within PSNC, more than ever, that they need to look at their structure. With the resources they have, they are finding there are more and more things they cannot do. The NHS&I teams are bigger and better resourced and this is difficult for the PSNC to deal with, as they will want to move at pace and the PSNC are always the ones saying no (to research, speak to committee, etc.) He feels that this report is coming at the right time for the organisation.

PC noted that being a member of the panel, he didn't think it would be appropriate to offer his opinion on anything, as it could be misconstrued. There are many people who are concerned and the worst place for it was the PSNC sponsored forum, which he found disappointing but informative. He thought some of the comments from LPCs, particularly in regards to the PSNC, showed a surprising lack of insight. He noted that the principle thing for him is a lack of unified vision – the gap between LPCs and PSNC is too wide and it's too much for regional reps, there's no comradeship in it.

DB stated that he felt the PRSC and review team needed to start thinking about contingency plans in light of Covid-19 [to be discussed as AOB]

AP noted that it had gone very quiet and disappeared from his perspective.

RBa noted that personally she wanted governance to come out of the review, and she is pleased that it is being addressed. She noted that she is worried about the framing of the outcome and how it's going to be framed to people – there are people like Pharmacy Voice who have tried to do similar to this review and nothing changed. RBa asked for assurance

that this review and the recommendations will make a difference and be the change that is so needed.

DW reassured RBa that he is building a plan in his head which will please most people. He did not want to discuss it today but at the next meeting, but noted that he would also be upset if the report didn't land. He thinks people recognise that it needs to change and noted that if we don't get the contract right, and what the PSNC does right, then everything else is pointless.

RBa also noted that in the contractor surveys a lot of people have selected option 3 'Not sure.' She noted that some of it is apathy, but some of it is also lack of knowledge, and both need to be addressed.

DW stated that there are two gaps that need addressing: the gap between LPCs and PSNC and gap between PSNC and contractors. There needs to be real engagement.

SD noted there is a third gap: the PSNC contractors. The PSNC is paid for by the contractors, the money might go through LPC accounts but it is the contractors money. The challenge the PSNC has it how they recognise and bring in new people. Local vs. global macro-economic issues is only getting wider.

DW noted that he liked the community pharmacy local name. There is a stigma with LPCs and the LPC title makes it look old. One of his recommendations will be to change the names across the country so that it's seen as more positive and so it's attractive to young people.

RB noted that her LPC changed their name, not for contractors but for the wider audience, and it still helps because it's seen in a different light.

DW let's standardise it.

MI totally agrees with the name change and had nothing more to add.

SS had nothing more to add.

AA noted that the survey results highlighted to him that LPCs are inconsistent and they need help, support and guidance.

DW agreed that support and infrastructure needs to be in place. DW noted that the PSNC had taken some training away because they couldn't afford it. He also noted that the equality and diversity survey answers were shocking and this is also why there needs to be more training. One of the responses to the survey was 'why are you worried about GDPR?' There's no understanding about patient confidentiality etc. and how to reduce risk.

Finally, DW noted that things had gone quiet for him and he was eager to write a report/recs that will not only be acted upon, but that benefits the most and upsets the least amount of people.

7) Website review findings

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 by Hannah Family and began on 17th January 2020 and completed on 2nd March 2020. Seven websites were reviewed and then the findings of this discussed with the whole review team, before proceeding to review the remaining 62 websites.

DW shared the report with the PRSC prior to the meeting and asked them for their thoughts.
Main comments:

- RB stated that there needs to be a really clear definition of what should be on an LPC website. There are so many variations because there can't be a straightforward standard. The review team also needs to be clear about local and national content and what is relevant to each individual LPC.
- DW noted that looking at the governance documents, it is clear there needs to be an annual review.
- VR noted that it is frustrating that not everybody can access relevant pages on LPC websites. MI agreed – the ways websites are used can be really powerful if everything is made public. SD stated that he was struggling to see what shouldn't be made publicly available – minutes of meetings, etc. should be available. SS agreed that contractors are paying for LPC meetings and so minutes of those meetings should be available. AP asked why we need to hide behind websites when meetings could be streamed online?
- RBa confused by colours on the graphs – these need to be made clearer.
- Re: amount of funds held in reserves: MI noted that it is important to put a total figure for the amount in reserves. For many contractors, this will be an interesting figure. RB noted that her LPC also attracts non-levy funding.
- SS asked why there can't be a PSNC website, which includes a drop down menu for each LPC or community pharmacy area (i.e. the PSNC website takes you to the different microsites). PC noted that this would create peer-group pressure as well.

ACTION Hannah Family (HF): Make colours more distinctive on website review charts/graphs

DW noted that there is going to be some cost associated with the plans he intends to recommend. He asked the PRSC if it would be inappropriate of him to ask each LPC to put 5% of their underspend into a transformation fund (currently at a total of around 8m between all LPCs)? This would only apply if the LPC had above the 50% of their yearly levy in reserve.

VR stated that some LPCs may question why they are putting in £2000 and others only £500.

DW perhaps a standard fee then? Transformation is not going to be cheap, and the only place he can see that there is money at the moment is in LPCs underspend.

MI noted that when contractors become aware of how much is in the underspend, there will be noise and demand for that money to be returned. It needs to be an objective, this is where the money is, this is why it is sat here for the right reasons, and this is why we're taking it to use it for these recommendations because they will deliver this benefit for the future. Without this story, there will be a lot of noise.

DW asked how he could calculate the estimate each LPC would need to put in?

SS why not a survey where we all declare what our reserves are?

RW some LOCs are sitting on reserves but it's not based on income it's based on running costs. If you have an LPC with a big reserve it might just be they have big running costs

RB we have got reserves but then we don't have a provider company

PC as a cornerstone, my last resort would be to ask contractors for money

RB not all LPCs charge the same levy

SS I think that needs to change

DW we will talk about that next time

ACTION DW: Add levy to next PRSC meeting agenda

8) Contractor survey initial findings

DW shared with the PRSC the data from the contractor survey. He noted that the actual number of contractor voices represented is 6,462 out of 11,000 or so. He has previously stated that it was 7,400 because there was a mistake with double counting. He is very pleased with the amount of data given that it was a PQS month, although he didn't feel he got enough of a response from any of the LPCs. The process used this time would need to be severely enhanced to get a bigger local response, but if local contractors want to have a say over their LPC then this is the way to do it. The review team have enough data for the purpose of this review.

DW will break the data down by AIM, CCA and Independents in the report to see where this is agreement and disagreement. He noted that this is not a vote, but he wants to see where people agree and disagree and why they are making decisions. It's not about who has the loudest voice, but the most sensible way forward with the PRSC support.

SD stated that he appreciates DW saying that it's not a vote, but proportionately it's very London and how will the review team counterbalance that?

DW will multiply the CCA response by how many contractors they're representing, create a chart to 100% (number of contractors representing that one response), and will do the same for Independents and AIM. The percentage will no doubt look very different, and so will

weigh the response by how many contractors they represent. He stated that he will not break them down by London and the rest of the country.

DW noted that at this stage the analysis was not about picking up on different LPCs, but about getting a general feel for where people were. He noted that the responses didn't surprise him. He asked the PRSC for their thoughts on the data.

AP, VR and RBa similarly stated that the volume of 'neither agree or disagree' was a reflection on how much some people do not know – apathy or lack of knowledge.

DW stated that from the response to Q.5, there is a clear feeling from contractors that the PSNC isn't capturing their voice. This may not be the case, but the perception is such.

SD noted that this may well be true and he felt there needed to be a 'I don't know' box for that reason. The distance between the front line and PSNC is so great.

DW agreed and apologised for not including an 'I don't know' option in the survey.

DB noted that if you are a contractor and financially not in a good place – and a lot of people are not in a good place atm – you are not going to answer the survey favourably of the PSNC. He noted that the PSNC has done some good in the past couple of years.

DW stated that the PSNC and the work they have been doing is featured substantially in the results.

PC noted the need to consider where the economic pressures are coming from, and how they have perhaps driven the answers. He stated that the economic pressure is on *everyone*, that's a neutral effect, there's no sector in community pharmacy that is thriving under the current conditions. Independents may be articulating that more and making more noise.

DW noted that it comes across in the results that contractors appreciate the communication from PSNC and that it is good.

SD clarified that communication of the different aspects of the contractual framework, communication regarding PQS, etc. are different from what the PSNC does.

RBa stated that it was interesting that contractors thought the levy represented good value for money.

DW the LPC survey results are generally more positive, and highlights the variation in the well-functioning LPCs and those not functioning well. There is still a significant proportion of people unhappy. DW asked the PRSC is they had any other comments.

RB noted that the contractor view around how LPCs make decisions they don't get to vote on. Does it come down to understanding? How do we make that more transparent?

DW they have voted in the LPC members, so therefore it is not really their vote?

RBa noted that it's a lack of understanding of the politics and suggested inviting a contractor every time and rotating the contractors that join – this is how you will hear the views of the silent ones and how you will get new people joining.

Other comments:

- DW stated the results highlighted that a lack of sharing good practice has come through very clearly in the results – there is not forum for sharing good practice beyond local LPCs.
- DB difference between LPC survey and contractor survey is interesting – wide variations between the two between around roles and responsibilities. DW understanding is that LPCs probably have a better view than the contractors?
- DB typo on Q.33 – should say PCNs not VPNs
- SS Q.33 second paragraph should say 'for'
- VR noted the quotes are useful and so although the report needs to be succinct, it would be helpful to include them. DW will include quotes on the website.

9) E.mail expressing concerns regarding survey complexity

DW explained to the PRSC that he received an email from one chief officer who had expressed concern that the issues presented in the survey questions were too complex. He suggested position papers giving pros and cons of the situation relating to each of the questions might have been helpful, and also suggested independently facilitated sessions would help staff better understand. DW had promised that he would present the email to the PRSC and ask for their response.

The PRSC were not sure what the CO was asking. The PRSC agreed that the email was sent too late – on the 28th February – and the vast majority of people filled the survey in fine. The responses indicate that the survey questions were also understood by the majority of people. Such concerns should have been relayed sooner.

DB noted that some people felt some questions were ambiguous, but the survey would have never been perfect. RB noted that the comment boxes allowed people to explain their answer if they were not sure.

RBa noted that her LPC didn't send the survey out to contractors until the 19th Feb because they wanted to have a 'survey meeting' first. DW suggested that a similar survey should be sent out annually and LPCs should need to meet certain response rates.

10) Launch event (ZL)

The PRSC is asked to consider how DW can best communicate the report of the independent review.

The key audiences for the report are: PSNC, LPCs, community pharmacy contractors and the pharmacy media. A key message from LPCs has been the need for LPC Members and PSNC Members to receive the report at the same time, and to have time to consider it before the press reports on it. This is challenging, because with so many people included in LPCs and PSNC it is likely that people may very quickly start to talk about the report on social media and leak elements to the press.

There are other parameters to consider including:

- When the report will be ready (likely to be mid-late April)
- The need to give the pharmacy press access to Professor Wright to ask questions of him
- The PSNC/LPC meeting being held on May 5th – this is the meeting at which PSNC and the LPCs will first be able to discuss the report, and Professor Wright is keen that media coverage does not happen before this date, to avoid press coverage influencing the debate.

Taking into account all of these factors, a proposed communications plan is set out as follows:

Friday 24 April: The report is sent to PSNC and LPC Members (this can be done via PSNC's mailing lists) under embargo ie with clear instructions that this is to remain confidential until May 5th in order to give both LPCs and PSNC time to consider and prepare any initial media responses.

Friday 24 April: The report is sent to the pharmacy press under embargo until midday on May 5th (this is a long embargo).

Wednesday 29 April: Professor Wright to host a press conference, offering the pharmacy media a briefing on the embargoed report and the chance to ask him questions about it. PSNC will also take questions from the pharmacy press on this date.

Tuesday 5 May: National meeting of LPCs to be held, without the pharmacy press present, and the embargo lifts, meaning the pharmacy press can publish their stories from midday.

Note: The agenda for the May 5th conference is being decided by a working group of PSNC and LPC representatives. The intention is for that group to finalise the agenda on **Monday 27 April**. The meeting will be livestreamed so that all LPC Members can take part digitally if they wish to.

The event will be live streamed. All LPCs members can tune in and watch it afterwards.

SS and MI noted that the momentum will die off if the embargo/time between sending out the report and holding the national meeting is too long. AP argued for five days – understanding that people will want to listen to DW speak, not read the report.

Agreement on adjusted plan: **Report goes out on Wednesday 29 April to LPC and PSNC members and it launches on the Thursday 30 April.**

VR asked if the PRSC can talk about what comes next at the next PRSC meeting.

ACTION DW: Add what comes next to May PRSC meeting agenda

11) Message for pharmacy media

Not discussed.

12) Any other business

No other business.

3.30pm Finish