Pharmaceutical Services Negotiating Committee Agenda

for the meetings to be held on 24th and 25th June 2020

Zoom virtual meetings

Members: Reena Barai, Richard Bradley, David Broome, Mark Burdon, Peter Cattee, Ian Cubbin, Marc Donovan, Samantha Fisher, Mark Griffiths, Alice Hare, Jas Heer, Tricia Kennerley, Clare Kerr, Sunil Kochhar, Margaret MacRury, Fin McCaul, Niamh McMillan, Has Modi, Garry Myers, Bharat Patel, Indrajit Patel, Prakash Patel, Umesh Patel, Jay Patel, Janice Perkins, Adrian Price, Sian Retallick, Anil Sharma, Stephen Thomas, Faisal Tuddy, Gary Warner

Chair: Sue Killen

Wednesday 24th June 2020	**09:30**
1. Welcome from Chair	
2. Apologies for absence	
3. Conflicts or declarations of interest	
4. Matters arising **Appendix 01/06/2020**	
5. Follow-up from the previous meeting **Appendix 02/06/2020**	**09:45-10.30**
6. Current work on CPCF Services	**10:30-11.30**
7. Break	**11.30-13.00**
8. Current and Future Funding	**13:00-15.00**
9. Close	**15.00**
Thursday 25th June 2020	
10. Outstanding items and issues from Day 1	**09:30-09.45**
11. Future Structures and Organisations **Appendix 03/06/2020**	**09:45-11.45**
12. Break	**11.45-12.30**
13. Current and Future Risks	**12:30-13.30**
14. Looking ahead	**13:30-13.45**
15. Close	**13.45**

Matters Arising

Meeting Reference	Matter Arising	Action
6 February 2020 (6.6)	LPC and Contractor Support Subcommittee will establish a working group with LPCs to create the agenda for the national meeting of LPCs.	The working group was created and the virtual meeting of LPCs and PSNC will take place on 8th July.
6 February 2020 (9.1)	A summary of the key points of the annual review to be circulated to the Committee and the office to approach other pharmacy bodies and invite feedback and contributions. The office will then write to the Government on these issues.	Discussion and data capture has started.
20 May 2020 (6.2)	Rapid Action Team which will be a standing item on the LCS subcommittee agenda as it evolves in the second phase of the NHS response to COVID-19 to support contractors and LPCs and PSNC. As part of this process feedback is sought from PSNC members which should be sent to Richard Brown [and Gordon Hockey].	Ongoing
20 May 2020 (6.5)	PSNC to seek a further cash advance of £50m at the end of May.	Ministers agreed to inject a further £50m of advanced funding into Community Pharmacies at the end of May.

Follow-up from the previous meeting

This paper provides an update on work that has been undertaken since the May 2020 Committee meeting on the priority areas identified for action following the acute phase of the COVID-19 pandemic. The priority areas were:

1. Funding;
2. Rescoping the CPCF;
3. Technology;
4. The flu vaccination service 2020/21; and
5. Regulatory flexibility.

1. Funding

Getting a COVID-19-related funding package settled: recognition of the sectors' COVID-19 costs; reconciliation of the £350m advances; and agreement on the use/allocation of the unallocated funds within the CPCF.

2. Rescoping the CPCF

Having a sensible conversation about what NHSE&I now wants from us as a sector: resetting the CPCF in the light of COVID-19; aligning the CPCF to national priorities; increasing the contract sum and aligning distribution to reviewed and prioritised services and requirements.

Discussions on a revised Pharmacy Quality Scheme (PQS) have started and the Committee were briefed on the initial proposals from NHSE&I by email and at the Committee update session on 16th June 2020. A further update will be provided during agenda item 8.

Initial discussions have been undertaken with NHSE&I and DHSC on outstanding matters related to the Discharge Medicines Service (DMS) and the point at which it could commence. Further discussions on this will take place shortly, but the priority for NHSE&I is first to agree a revised PQS.

As discussed at the Committee update session on 16th June 2020, at the time of writing this paper, HM Government is still considering its policy on shielding certain citizens to protect them from COVID-19. Once this policy is determined, it will inform their policy on the future of the Pandemic Delivery Service. We anticipate that there will be developments on this matter before the Committee meeting, in which case an update will be provided during agenda item 8.

Several discussions with NHSE&I and DHSC have also taken place to discuss all the existing contractual services and requirements to consider whether amendments need to be made to these to support their provision during the new normal period.

The following table summarises the main CPCF requirements and potential changes that have been discussed with NHSE&I and DHSC.

Discussion point 1:

a. Consider the information in the table below and highlight any additional changes which could be considered to the Terms of Service requirements.
b. Consider the questions posed regarding the CPPQ (highlighted in grey).

Aspect of Terms of Service	**Does this need updating in light of COVID-19?** **Would any change require new regulations or Directions or revised Approved Particulars or PSNC guidance?**
Essential Services	
Dispensing medicines and appliances	The NHS Regulations provide already that for EPS prescriptions a person does not have to be physically present on the premises to request a contractor to dispense them. Hard copy prescription may be presented by the patient's agent/volunteer. Urgent supply at the request of a prescriber has been used with the faxing of a hard copy prescription in some cases during the outbreak to assist supply – this is reducing and being replaced by EPS.
Additional considerations with dispensing and supply	Remove the requirement for patient signatures; removal of prescription charge not accepted by Government. Advice if no evidence of a declaration provided – advice may be given by telephone. Measuring and fitting of an appliance, e.g. a truss – full PPE would be required for such direct patient care. Appropriate advice – may be given by telephone – patient conversations must be confidential. **PSNC guidance to contractors may be needed**.
Disposal service in respect of unwanted drugs	Advice issued jointly by PSNC, NPA, RPS and Patient Safety Group.
Prescription linked healthy lifestyle interventions	Appropriate advice – may be given by telephone – patient conversations must be confidential. **PSNC guidance to contractors may be needed**.
Public health campaigns	What is requested by NHSE&I may change and be more internet focused.

Signposting	Appropriate advice – may be given by telephone – patient conversations must be confidential. **PSNC guidance to contractors may be needed**. Applies to those 'using the pharmacy' by telephone etc. and for prescriptions.
Support for self-care	Applies to those remote from the pharmacy and consideration needed as to how this can be provided generally and for individual patients. **PSNC guidance to contractors may be needed**.
Clinical Governance	
Practice leaflet	Make available on the pharmacy website; print off in the pharmacy if required?
Publishing information on availability of the Essential and Advance services	On the pharmacy website if there is one.
Annual Patient Satisfaction Survey	We have already agreed in negotiations to revise the CPPQ to make it more relevant and so that it can be more applicable for remote users.
Monitoring of drugs/appliances that are out of stock but owed to patients	OK - no change required.
Co-operation with inspections / reviews	OK - no change required.
Maintaining compliance with the Equalities Act 2010	OK - no change required. Separately there is ongoing work on MDS/MCAs with the LPCs.
Clinical Audit Programme (including at least one pharmacy-audit)	Outstanding PSNC request to remove the requirement for the pharmacy-selected audit.
Arrangements ensuring stock is procured and handled in an appropriate way	OK - no change required.
Arrangements for maintenance of equipment used in pharmacy services	OK - no change required.

Use of approved incident reporting system, with arrangements to analyse and respond to critical incidents	OK - no change required.
Arrangements (including record keeping) for dealing with patient safety communications from the Secretary of State	OK - no change required. DHSC noted that there had been a lot of work related to this during the pandemic.
Appropriate Standard Operating Procedures for: dispensing drugs and appliances, repeatable prescriptions, providing advice for people caring for themselves or family	OK - no change required. DHSC noted that there had been a lot of work related to this during the pandemic.
Appointment of a clinical governance lead	5-year deal PSNC request to remove this.
Appropriate safeguarding procedures	OK - no change required. Of relevance to the pandemic delivery service.
Monitoring arrangements in respect of the Health and Safety at Work Act 1974	OK - no change required. However, the advice to undertake individual risk assessments on staff is a priority for the NHS and it is something they want to include in the H1 revised PQS.
Clinical effectiveness programme ensuring adequate advice for: provision of drugs with a repeatable prescription, provision of appliances with prescription/repeatable prescription and for people caring for their families	OK - no change required. Noted the shared desire to see a greater shift to use of eRD.
Staff and Management Programme: induction and training of staff, checking of qualifications and references of NHS staff, supporting development needs, addressing poor	OK - no change required, but note the point above regarding risk assessments for individual staff members.

performance, arrangements for protected disclosure and non-protected disclosures	
Information governance programme – compliance with approved procedures for information management and security and annual self-assessment	The need to complete the DSP toolkit has been delayed.
Premises standards programme – system for maintaining cleanliness to minimise risk and compliance with any standards ensuring an appropriate environment for receiving NHS health care.	DHSC and NHSE&I keen to see the revised need for infection control measures, regular cleaning and social distancing, as a result of the pandemic, are reflected in the requirements. **Revise Approved Particulars – Premises**.
Future amendments to Terms of Service	
Healthy Living Pharmacy	Whilst most pharmacies are HLPs, it was recognised that the approach to HLP needed to be reconsidered in the light of COVID-19, as some elements of the approach to healthy living promotion may change forever. Further discussions will be undertaken on this to consider options.
Discharge Medicine Service	Discussed elsewhere in the paper.
IT requirements (NHSmail, SCR, DoS updates etc)	Still fine to implement this in the autumn (subject to whenever regulations can be updated).
Safeguarding level 2 training	Still fine to implement this in the autumn (subject to whenever regulations can be updated).
Notification of entering administration	Still fine to implement this in the autumn (subject to whenever regulations can be updated).
Contract management and monitoring data to be submitted electronically	Still fine to implement this in the autumn (subject to whenever regulations can be updated), but the documents to be submitted by contractors are still to be discussed and agreed between PSNC and NHSE&I in advance, e.g. CPAF.

Data sharing on public health campaigns	Still fine to implement this in the autumn (subject to whenever regulations can be updated), but the data to be submitted by contractors are still to be discussed and agreed between PSNC and NHSE&I. Proposal awaited from NHSE&I.
MHRA Central Alerting System	Still fine to implement this in the autumn (subject to whenever regulations can be updated), subject to the practicalities needing to be considered. NHSE&I are working with the MHRA to seek to use the NHSmail shared mailboxes by default.
Changing the length of Notice of Commencement to enable transfer of EPS nominations	Still fine to implement this in the autumn (subject to whenever regulations can be updated).

3. Technology

Greater focus on and progress with technology: Track and trace, Locker boxes, virtual consultations, real time exemption checking, managing workflow, patient/pharmacy/GP communications. In general, ensuring the technology is in place to enable contractors to retrofit services/practices digitally, and having reporting systems in place so that services and added value of contractors is captured.

Video consultations

The joint Community Pharmacy IT Group, for which PSNC provides the secretariat, discussed video consultations at its recent meeting and agreed some collaborative working by several contractors to trial use of the technology and to share any learnings more widely.

The office is also identifying contractors who have already used video consultation technology during the pandemic to see whether case studies can be created to illustrate the benefits of adopting this technology to the wider contractor group.

RTEC

Real Time Exemption Checking (RTEC) has been rolled out to Positive Solutions and Invatech Health customers and EMIS Health and Cegedim Rx are testing RTEC additions to their PMR software ahead of rollout, which is likely to be during the next two months.

4. Flu vaccination service 2020/21

Getting the flu service up and running: a template for the safe and effective delivery of other services in the current climate; having an UCDIG-type group to get a national approach that can be operationalised at scale across England; ensuring that community pharmacy has its share of any additional patients identified for flu vaccinations in 2020.

Following the last Committee meeting, a meeting was held with the flu vaccination lead at NHSE&I to discuss potential changes to the service to provide increased flexibility in the way contractors can deliver the service. This included the points discuss at the May 2020 meeting:

a. Allow the vaccination of care home staff in their workplace;
b. Provide flexibility for contractors to undertake vaccination within the pharmacy premises, but outside the consultation room, where this supports better social distancing and it can be undertaken in a way which maintains patient safety and confidentiality;
c. Provide flexibility for contractors to undertake vaccination off the pharmacy premises, in locations within the vicinity of the pharmacy; and
d. A continued ability to flex pharmacy opening hours, so that the pharmacy could focus on vaccination at certain times of the day or week, rather than providing all other pharmaceutical services.

We have also asked NHSE&I to obtain clear guidance from Public Health England (PHE) on the appropriate PPE which should be used when providing the service.

It has also been confirmed that both Sonar Informatics and Pinnacle Health are developing functionality to allow patients to complete their pre-vaccination questionnaire online, in advance of visiting the pharmacy, to help to minimise their time spent in the pharmacy.

At the time of writing this paper, DHSC was still considering the options for the extension of the eligible patient groups and the target levels for vaccination of the current eligible groups. The eventual decision on this will be informed by the number of additional doses of vaccine they have been able to obtain from manufacturers for supply to the UK.

Costs for PPE and other additional consumables which will be required to provide the service this year are being collected and will be used to update the cost model ahead of discussions on funding with NHSE&I. Contractors' assessments of any additional time to undertake the service this year will also be sought.

The CCA organised two meetings for the pharmacy bodies to discuss the approach which could be taken to provision of the service this year and these will be followed with a meeting of the bodies with NHSE&I and DHSC on 17th June 2020.

A group of LPC representatives have been recruited to provide additional input into planning for the service and the development of guidance and resources. A draft PSNC Briefing for contractors has been written, explaining the new flexibilities which may be available to contractors, if they are agreed by NHSE&I and providing a set of points which contractors would need to consider and plan for if they are to use any of the flexibilities. The LPC group is currently reviewing this document. Committee members with comments on the document can send them to David Onuoha.

5. Regulatory flexibility

Flexibility of regulations: to allow verbal consent for services, and off-site provision. CPCS needs a broader remit: more conditions and the use of POMs, where appropriate via PGDs.

Reduce bureaucracy and paper-filling: eliminating the need for quarterly data returns, using the MYS portal more for submission of information.

Consent and remote working

At the May 2020 Committee meeting, there was a discussion on the provision of pharmacy services off the pharmacy premises. The discussion did not stretch to cover remote provision of services where the pharmacist or staff member providing the service are not on the pharmacy premises and neither is the patient.

For example, this could involve a pharmacist working from home, because they are in a shielded group, providing the Community Pharmacist Consultation Service (CPCS) by phone or video consultation to a patient in their own home. An alternative scenario could involve a pharmacist speaking from a call centre or office owned by the contractor to patients in their own homes.

This type of scenario has been seen during the pandemic with pharmacists working from home, taking calls as part of the COVID-19 Pharmacy Clinical Assessment Service (CAS). It provides a "pharmacy equivalent" of the way in which many GPs and other health professionals have been able to work more flexibly, including from home and it also reflects the wider changes across society that many organisations have adopted during lockdown.

DHSC and NHSE&I are open to consider amending some service requirements to allow provision of remote services to patients from locations other than the pharmacy. Any such changes could be made for the duration of the pandemic or they could be enduring changes.

Such changes could bring greater flexibility to the way contractors are able to operate their businesses, which many would see as being very valuable, but it also potentially weakens the link between the provision of pharmacy services and the network of pharmacies in the minds of patients and NHS policy makers. This could have unintended consequences for the sector in due course.

The changes could potentially be applied to MUR, NMS, CPCS, DMS, provision of self-care and healthy living advice, and advice on prescriptions (dispensing and repeat dispensing). With agreement from local commissioners, pharmacies could also apply the approach to some locally commissioned services, such as EHC consultations.

If the approach was allowed and adopted by contractors, appropriate and secure arrangements to remotely access relevant IT systems would be necessary and requirements to maintain patient confidentiality in the location where the pharmacy staff member is working would be needed. These matters have already been successfully tackled in the case of pharmacists working remotely for the COVID-19 Pharmacy CAS.

Discussion point 2:

a. Would contractors want the opportunity to provide remote services to patients from locations other than the pharmacy and would PSNC want to seek this new flexibility?

b. Are there any potential problems with this approach or future consequences which should be considered?
c. If you support changes being made to allow the provision of remote services to patients from locations other than the pharmacy:
    i. should this only apply during the pandemic or should it be an enduring change?
    ii. should any restrictions be placed on the way this flexibility can be used, e.g. remote services are only provided during the opening hours of the pharmacy, so a face-to-face consultation can be organised, if required or a remote approach can only be applied to specific services.

CPCS

The next development of the CPCS will be the rollout of the GP CPCS service. That service is still being piloted and we are organising another virtual meeting of the LPCs involved in the pilots to support collaborative working. NHSE&I have also agreed to re-start the national reference group for the service, with a meeting being planned in July 2020.

Two of the pilot sites will be trialling the use of electronic triage systems, as part of the GP clinical systems, with one disposition being a referral to GP CPCS. With the wholesale adoption of total triage processes in general practice during the pandemic, this is an important development to ensure that the GP CPCS can fit into the new normal for general practice.

Reducing bureaucracy

Further meetings have been held with NHSE&I and DHSC to discuss potential changes to the CPCF to allow for the pandemic new normal. These have included discussions on removing unnecessary bureaucracy in line with the points raised at the May 2020 meeting, but we are yet to get to firm decisions being made by NHSE&I and DHSC.

The NHSBSA MYS portal is now effectively the default option for payment claims and data submission to the NHS for CPCF services.

Flexible provision – days and opening hours

During the outbreak, the Secretary of State's declaration of an emergency under the regulations (made at the same time the Pandemic Delivery Service was introduced) activated certain provisions of the NHS regulations. These enabled contractors to change opening days and times with 24-hours' notice to NHSE&I, provided that NHSE&I does not object; and more easily relocate premises.

PSNC has already indicated to DHSC its desire that this flexibility continue during the outbreak, although the likelihood is that it will continue only for as long as the pandemic delivery service is in place.

Consideration is being given to the terms of service provisions on opening hours to consider if ongoing greater flexibility for contractors should be introduced so that:

- Contractors could make minor adjustments to core opening hours and notify these to patients and NHSE&I (to permit minor changes in opening hours and lunch breaks);
- More generous provisions to contractors in the event of service continuity issues (for example a no show by a locum);
- Contractors could provide or stop providing supplementary opening hours with a shorter notice period to patients and NHSE&I; and
- Contractors could close the pharmacy for short periods of time (with notice) for protected learning.

This measure would help to take the focus off minor breaches of opening hours and reduce the number and cost (in resources and fines) of associated breach notices, which have not been a feature of the outbreak to date.

Discussion point 3:

a. Are there more changes that the Committee would want to see to the opening hours provisions of the regulations?
b. Is the Committee willing to consider procedures that make it easier for NHSE&I to direct opening hours on, for example, Bank Holidays?

The Independent Review into Community Pharmacy Contractor Representation and Support

Introduction

The Independent Review of Community Pharmacy Contractor Representation and Support was shared with the Committee on Wednesday 17 June. As Committee Members will have read, it sets out 33 recommendations (copied at the end of this paper) for the future of LPCs and PSNC, as well as identifying a number of issues with the ways in which PSNC and the LPCs are currently working.

This PSNC discussion is an opportunity for Committee Members to share their initial reflections on Professor Wright's report and to consider ways forward. This is also PSNC's opportunity to come up with its questions for Professor Wright ahead of the event on 8 July.

Next Steps

There is no doubt, given the issues raised and the views of PSNC Members which were included in the report, that PSNC (and the LPCs) want change and need to change, in one way or another. As a first step in exploring that together, PSNC and LPC Members will meet in a digital meeting on Wednesday 8 July. That event has been planned by a PSNC-LPC Working Group and will consist of:

- A 45-minute presentation from Professor Wright, during which he will talk about the rationale for his recommendations, and also try to answer questions that PSNC and LPCs have been invited to submit to him in advance
- Questions from attendees (to be chaired by Professor Wright's team)
- Discussion in groups

The discussion groups will all include a mix of PSNC and LPC representatives, and the conversations will be facilitated by members of both Professor Wright's Steering Committee and the PSNC-LPC event working group. The aim will be to gather ideas and thoughts on how PSNC and the LPCs should take conversations forward: whether we will need a steering group; how we will resource next steps; which recommendations or issues we need to prioritise; and how we might form working groups to do some of the detailed thinking.

The discussion today gives PSNC Members a chance to think about some of these things ahead of the meeting with LPCs.

PSNC Discussion Plan

Questions for discussion groups to consider are:

- What are your initial reactions to the review findings and recommendations?
- Is there anything you would disagree with?
- Are there recommendations that you would add?
- Which recommendations would you prioritise over others?
- What questions do you have for Professor Wright?
- What are the next steps if we are to make progress?

- How should PSNC and LPCs progress things over the summer and beyond?

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