Pharmaceutical Services Negotiating Committee meeting

on 20th and 21st May 2020

Zoom virtual meetings

Present: 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, Sue Killen (Chair), Sunil Kochhar, Margaret MacRury, Fin McCaul, Has Modi, Lucy Morton-Channon, 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

In Attendance: Simon Dukes, Shiné Brownsell, Alastair Buxton, Jack Cresswell, Mike Dent, Michael Digby, Gordon Hockey, Zoe Long, Melinda Mabbutt, Niamh McMillan, Layla Rahman, Suraj Shah, Rob Thomas

Item 1 – Welcome from Chair

1.1 The Chair welcomed Reena Barai and Niamh McMillan to the Committee. The Chair also gave her best wishes on behalf of everyone to Lucy Morton-Channon, as she is about to go on maternity leave.

Item 2 – Apologies for absence

2.1 No apologies for absence were received for the 20th May 2020. Janice Perkins sent her apologies for 21st May 2020.

Item 3 – Conflicts or declaration of interest

3.1 The Chair confirmed that the Committee will be receiving a notification from Shiné Brownsell to update their conflicts of interest forms.

Item 4 – Minutes of the May meeting

4.1 The minutes of the meeting which took place on 6th February 2020 were approved.

Item 5 – Matters Arising

5.1 Sam Fisher reported that the next national meeting of LPCs will take place on 8th July 2020.

5.2 The Chief Executive reported that the independent review was placed on hold at the start of the pandemic; however, Professor David Wright has begun working on the review again. The office and Richard Brown have been working on capturing data and the report will be published in due course.

Item 6 – Subcommittee feedback

6.1 LRA: Ian Cubbin reported that the LRA subcommittee had considered, amongst other matters, a proposal to defer the requirement for a PNA by one year, that has since been accepted by the Government and changes to the market entry regulations arising from the recent suspension of activity, which again had been accepted by the Government. He added that these proposed changes to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 were in the LRA draft minutes which had been circulated. He also indicated that work by Mark Donovan

and Gordon Hockey on proposals for the 2019/20 pre-registration trainee cohort had largely been accepted by the GPhC and that PSNC had already indicated to NHSE&I the need for discussions on financial support for the revised training. Approval was sought and given by the Committee for the recommendations – the proposed changes to the NHS regulation.

6.2 LCS: Sam Fisher indicated that the LCS subcommittee had discussed a number of topical issues including: First, the Wright review of LPCs and PSNC for which various provisional dates were discussed for publication of the report and the LPC discussion of the report. These will be communicated to LPCs and contractors. Second the Rapid Action Group which will be a standing item on the 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].

6.3 CPA: Tricia Kennerley reported that the CPA subcommittee had held a useful meeting in the previous week. The subcommittee has revised communications and public affairs plans in light of COVID-19 with new plans including to revise our key messaging about the value and role of pharmacy through the pandemic; to update plans for engaging with GPs and working with the BMA; to update the policy asks; to continue to build on the new daily newsletters to contractors; and to consider communication and reputation risks for the sector linked to the pandemic.

6.4 RDF: The Committee approved the recommendation for the interim amendment to the PSNC Committee Members' Expenses Policy.

6.5 FunCon: Following a vote, the whole Committee approved the recommendation to seek a further cash advance of £50m at the end of May.

6.6 RAP: Adrian Price, the new Chair of the Panel, reported that the Committee had met recently and that the office will look at the provision of information to the Committee on Negotiating Team meetings; and the Committee will be asked to review the risk register at the next meeting. He also indicated that the RAP minutes are approved by RAP first and therefore will be circulated to the Committee in due course, as normal.

Item 7 - Discussion sessions

7.1 During the sessions the Committee explored the current environment and considered the consequences of the pandemic. The Committee also discussed what the sector should start doing, stop doing and continue to do during the 'new normal', and priority actions for PSNC.

Item 8 – Governance session

8.1 The elections of officers took place with the following results:

Chairman of Funding and Contract Subcommittee – Peter Cattee
Chairman of LPC and Implementation Support Subcommittee – Sam Fisher
Chairman of Legislation and Regulatory Affairs Subcommittee – Ian Cubin
Chairman of Resource Development and Finance Subcommittee – Mark Burdon
Chairman of Service Development Subcommittee – Gary Warner
Chairman of Communication and Public Affairs Subcommittee – Tricia Kennerley
Vice Chairman of PSNC – Bharat Patel

Election of Review and Audit Panel
The five committee members elected to the Review and Audit Panel of PSNC were Adrian Price, Umesh Patel, Indrajit Patel, Jay Patel and Janice Perkins.

Election of Appointments Panel
Garry Myers was elected to serve on the Appointments Panel alongside the subcommittee Chairs. Tricia Kennerley is now a member of the Panel as Chair of CPA and, therefore, the second person elected required clarification.

Election of Negotiating Team
The four committee members elected to serve on the Negotiating Team alongside the two subcommittee Chairs (Peter Cattee and Gary Warner), were Clare Kerr, Tricia Kennerley, Garry Myers, and Bharat Patel.

Multiple and Independent representatives' appointments
The members of the six subcommittees were agreed as follows:

FunCon: Peter Cattee (Chairman), David Broome, Jas Heer, Tricia Kennerley, Margaret MacRury, Has Modi, Garry Myers, Bharat Patel, Adrian Price and Anil Sharma.

LCS: Sam Fisher (Chairman), Alice Hare, Fin McCaul, Lucy Morton-Channon, Jay Patel, Indrajit Patel, Umesh Patel, Sian Retallick.

RDF: Mark Burdon (Chairman), Peter Cattee, Ian Cubin, Sam Fisher, Tricia Kennerley, Sue Killen, Gary Warner. [Bharat Patel is an observer.]

LRA: Ian Cubbin (Chairman), Marc Donovan, Sunil Kochhar, Janice Perkins, Stephen Thomas

SDS: Gary Warner (Chairman), Reena Barai, Richard Bradley, Clare Kerr, Prakash Patel, Faisal Tuddy

CPA: Tricia Kennerley (Chairman), David Broome, Clare Kerr, Sunil Kochhar, Fin McCaul, Jay Patel, Prakash Patel, Stephen Thomas

<u>Item 9 – Any other business</u>

9.1 The Chief Executive asked the Committee to provide feedback on the first virtual Committee meeting, where they felt it was successful and if there is anything that can be improved. It was suggested that the Committee may need to meet virtually for the rest of the year.

9.2 The Chair also thanked the office for all their hard work over the last two days.

Summary of points from discussion session 1 (20th May 2020)

During this introductory session the Committee explored what had changed during the pandemic, so we could then consider the consequences of this for the recovery phase and the 'new normal' that will follow the acute phase of the pandemic.

The following questions were used as prompts for the discussion. Key points from the group discussions and the points raised in the agenda paper are detailed below.

1. What have been the main factors shaping the environment during the pandemic?

a. Changes to working practices to allow for social distancing;
b. Flexible working arrangements;
c. Changes to the working practices of GPs – closed door surgeries, telephone triage, video consultations, increased use of EPS, reduced patient contact and extended PoT;
d. Greater collaborative working and flexibility across primary care and the community pharmacy sector, recognising that all professionals have had to work in different ways;
e. Supply shortages and increased cost of medicines (including OTCs) driven by increase in demand and restrictions on supply from China and India in particular;
f. Changes to consumer and patient expectations and habits, including a clear focus on the need to get their dispensed medicines and a step change in use of technology to work from home, which may have changed their selection of pharmacy;
g. The need to support Shielded patients – there was confusion in the early stages about who was covered by the delivery service, after the initial Government announcement and the lack of an elegant way to identify the patients;
h. Maintaining adequate staffing, including where staff were in the Shielded group, were C-19 positive or had a member of their household who were infected, or who had caring responsibilities; and
i. Lack of timely guidance from the Government and NHS – people just had to get on and make decisions.

2. What have been the main challenges for:

(i) contractors, as businesses and as employers;

a. Adapting to the rapidly changing environment;
b. Increased patient demand for self-care advice;
c. The volume surge in March 2020 with extended PoT and the inability to provide services;
d. Displaced patients from general practices and challenges liaising with practice staff who were working remotely;
e. Managing a massive increase in phone calls from patients. For many calls, an app to track progress with the reordering and dispensing of their prescriptions, would have addressed the patients' enquiries;

f. Issues around social distancing, including the small size of most consultation rooms, and how to implement distancing in pharmacies;
g. The difference between what was reported by politicians versus what the reality on the ground;
h. Availability and use of Personal Protective Equipment (PPE), including the conflicting views of PHE and the sector;
i. Procurement of stock, quotas and other supply / stock holding issues and variable performance of wholesalers;
j. Staff absences, overtime and fatigue;
k. Managing demand for deliveries and the lack of funding for most of these;
l. Introduction of new services, particularly the pandemic delivery service and challenges on the use of volunteers, including DBS checks;
m. Changes to existing services such as sexual health and substance misuse services, e.g. the move away from daily collection of methadone;
n. Financial pressures given expenditure, higher procurement costs and in many cases, a drop in OTC sales and the provision of NHS and private services;
o. Specific issues such as contamination, closures and hot site impacts;
p. Lack of innovation in the PMR sector in response to the challenges contractors were facing; and
q. Implementation of significant operational changes and the need to explain those to patients.

(ii) the sector; and

a. Support from politicians does not seem to be translating into more generous decision making / perceived inequality of treatment compared to GPs;
b. Concern over whether consumer habits will return to normal. For example, changed nominations, more working from home and more internet shopping may permanently change retail patterns and patients' choice of pharmacy. This will feed into shifts in valuation of businesses;
c. Shift of demand between contractors, e.g. towards DSPs, and across sectors, e.g. from hospital to community; and a change in the use of pharmacies (as the population shifted with lockdown);
d. Concern over whether independents can continue to be able to compete in procurement;
e. Further delay in implementation of cost saving initiatives factored into the 5-year CPCF; and
f. Initial lack of recognition of the sector as front-line workers by the state and the public.

(iii) PSNC.

a. Staff working at home, maintaining communications and management, sorting appropriate technology such as a VPN for PAC;
b. Sheer workload and pace of change at crisis peak highlights the general inadequate staffing levels compared to the role of the organisation;
c. Managing virtual NT and PSNC meetings - evening updates and other calls on time means there is limited differentiation between work and home life;
d. Slow NHSE&I / DHSC decision making process and issuing of comms; and

e. Ensuring the comms reach contractors and others – the website has provided a welcome single source of up to date information for contractors. Also, the challenge of ensuring contractors understand where the delays occur in the Government/NHS, and that it is not PSNC delaying progress.

3. How have we adapted to these challenges and what have we learned in doing so?

a. There has been a clear demonstration of the sector's agility and resilience;
b. Local decision making by contractors and within local government and the NHS helped the sector to cope. Contractors were making quick decisions for their patients, which were not necessarily in the interest of the pharmacy. They were taking things on trust and pushing regulations to the limit;
c. Changes to general working practices of pharmacies, e.g. undertaking more deliveries;
d. Maximising use of flexibility of opening hours;
e. Hub and spoke operations - for multiples with hubs, they were invaluable in allowing their overall network to cope with the peak demand; and
f. Reducing the supply of prescriptions in MCAs, where there was not a genuine patient need.

4. Is the world now a safer or more dangerous place for community pharmacy businesses?

a. There are opportunities ahead, but if the NHS doesn't see the worth of pharmacy in this time, when will they?
b. There is increased appreciation from the public for the work that pharmacy does at a local level, but we don't yet understand how people's behaviour and use of pharmacies and general practices will change in the new normal. For example, will we see a continuing trend to access all services remotely;
c. The community pharmacy network has demonstrated it is a key part of the wider community, and that the distributed network is an asset for both the public and the state; previously this would have been seen as a negative by some in the NHS;
d. The network demonstrated its resilience, but there is still a danger that the Government will use the pandemic to pave the way for a centralised supply system. The future is still services-led, alongside the supply function;
e. The disproportionate impact of C-19 on people with BAME heritage is a major concern for the sector, bearing in mind the demography of the employee and contractor workforce. Also, the pandemic's currently unknown impact on the mental health of the workforce could create problems over the next few years;
f. Is there a risk that we get caught out by a second peak of C-19 cases? And
g. There are also still many uncertainties related to the impact of Brexit, the C-19 recession, unemployment and the massive C-19 national debt.

Summary of points from discussion session 2 (21st May 2020)

Following the introductory discussions undertaken on 20th May 2020, this session explored detailed suggestions on things the sector should start doing, stop doing and continue to do during the ‘new normal’ phase after the acute phase of the pandemic.

There were six questions to help shape thinking on this:

1) What have we stopped doing and should carry on NOT DOING?

a) Temporary changes made to the CPCF requirements

Would we want to continue to not do some of the delayed or suspended CPCF requirements?

- CPPQ for 2020/21 and review the requirement in time for 2021/22, as agreed in the last round of negotiations;
- Clinical audits beyond those in PQS;
- Submission of quarterly NMS and MUR data;
- Updating practice leaflets – move to online information, as proposed in previous negotiations;
- Undertaking public health campaigns; and
- Submitting an annual report on NHS complaints.

b) Changes to local services or pharmacy practice

What changes have been made to stop doing things that we would want to continue not doing?

- Provision of multi-compartment compliance aids (MCAs) to care homes and individuals where there is no clinical need.

2) What have we stopped doing and should BRING BACK?

Now we are past the peak of the pandemic, should our policy on MURs be reviewed and if yes, what approach should PSNC now take?

There were mixed views on this matter, with some supporting removal of the service as previously agreed by the Committee and some believing the service should now be allowed to run its course for the rest of 2020/21.

It was noted by some, that should the service continue this year, the need to seek prior approval to provide remote MUR consultations should be removed.

Some groups suggested that a new service focussed on supporting people to manage LTCs should be considered.

What other activities have pharmacies stopped doing that we would wish to see being resumed?

- Supervised consumption of medication; and
- Other locally commissioned services which have been paused.

3) What have we started doing and would want to STOP in the new normal?

What new service requirements or changes to pharmacy practice would we not wish to retain in the new normal?

- Use of volunteers to deliver prescriptions;
- Requesting repeat prescriptions from practices on patients' behalf via email or scanning repeat slips;
- Increased use of emergency supplies at the request of the prescriber from dental and secondary care prescribers working remotely from the patient; and
- Provision of advice to patients on a wide range of topics, but without there being adequate funding from the NHS.

4) What have we started doing and would want to CONTINUE?

What new ways of working have been introduced during the pandemic, which we want to retain?

- Managing the patient journey, e.g. processing repeats (eRD), co-ordinating blood tests with their GP;
- Increased use of SCR and access to Additional Information;
- Use of video-consultation systems (and use of similar systems to support communication between healthcare professionals);
- Flexible working (e.g. phone consultations for EHC) and flexibility in opening hours, which would allow various activities to be undertaken, e.g. protected learning time. A flexible approach to support the seasonality of some pharmacies would also be beneficial;
- Less direction on how to operate from the NHS, allowing an outcomes-focused and person-centred approach;

- Improved relations with regional NHSE&I teams;
- Enhanced collaboration between pharmacy bodies;
- Physical protection of staff using screens etc.;
- NHS funded delivery service;
- Easier phone access to some GP practices. Similar measures need to be put in place in some pharmacies to allow other professionals easier access to the pharmacy team;
- Relaxed supervision requirements, e.g. handing out bagged-up and checked prescriptions; and
- Remote provision of guidance to patients after the delivery of their prescription.

5) What have we not been doing but should START?

Implementing agreed changes to the CPCF during 2020/21

Terms of Service changes

Should we seek to delay the implementation of any of these requirements beyond the autumn?

The consensus view seemed to be that most pharmacies were already complying with a lot of the new requirements, so they could be introduced this year, but a timetabled introduction in the autumn would be best. If there was a second peak in infection, there may be a need to further delay the introduction of the requirements.

Some concern was expressed over the ability of pharmacies to achieve HLP status during the pandemic.

The Pharmacy Quality Scheme for 2020/21

At what point do you think contractors will have capacity to start to engage with the PQS and at what point would we want to commence the scheme?

There was not a clear view on when contractors would have capacity to engage in a PQS; the variability in levels of infection across the country added to the complexity of assessing the situation.

There was a recognition that some activity could be introduced this year, with some of it deferred until next year, but full deferral would also be welcomed. It was noted that Wales have already deferred their equivalent scheme for a year.

Could pharmacy contractors start to undertake some of the training and other non-patient facing aspects of the scheme during the pandemic, if the patient facing aspects are deferred until after social distancing measures are removed?

There was not a clear view on what approach could be taken to introducing the new PQS, but some members supported the introduction of several of the training elements agreed for the new scheme, e.g. suicide awareness training and weight management, both of which are possibly now higher priorities due to the pandemic.

There was also support for using some PQS funding to introduce changes following the pandemic, e.g. to put video consultation systems in place in all pharmacies.

Commencing the rollout of new services

When do you think the rollout of Hepatitis C testing and DMS could commence?

The Hepatitis C service was viewed as a niche service, which would also require a good supply of PPE; it was not an early priority for rollout.

Rollout of DMS later this year was supported by all.

It is unclear what impact the change in the way GP services have been provided has had on their appetite for GP referral to CPCS. This will need to be discussed with NHSE&I.

Would you support a "soft launch" approach for DMS, whenever it is decided to start the service?

There was some support for using a soft launch approach.

What other things have pharmacies not been doing, but should now start?

- Introduction of the GP CPCS.

6) What other matters do we need to consider related to the pandemic and the new normal?

Are there other matters related to the pandemic and the new normal that PSNC needs to be considering?

- The need for more guidance to contractors on how to achieve social distancing to protect all staff, including those from BAME backgrounds. This includes the

potential need to make adjustments to premises, including consultation rooms (this also has funding implications);
- Adoption of remote consultation technology;
- Better information provision to patients about when their prescriptions are ready for collection, using apps etc.;
- Removing the need for patient exemption declarations;
- Utilising PCN pharmacy leads – could money be released from PQS to fund their work?
- Review the public health service offering, focused on priorities post-pandemic, e.g. weight management, NHS Health Check, alcohol;
- Offer antibody tests and COVID-19 vaccinations;
- How community pharmacy would respond to a second peak / further tightening of lockdown if cases rise again;
- Resilience of the supply chain, especially given manufacturing reductions in India and China, and Brexit;
- Pick up points and locker boxes to reduce queues. Still only on or outside of a pharmacy premises, not remotely;
- Preparation to participate in any reviews of the pandemic, such as Public Inquiries;
- Highlighting the access to and diversity of the pharmacy network and the value that results from this. Does this have an impact on the view of some in the NHS that the network is too large?
- Ability to amend prescriptions and generically substitute; and
- Greater use of independent prescribers in community pharmacies.

Provision of pharmacy services off the registered premises

Would we want to propose that pharmaceutical services could be provided off the registered premises, other than in the patient's home?

There was general support for provision of services off the pharmacy premises, including provision of flu vaccination within the vicinity of the pharmacy premises and vaccination of care home and hospice staff in their place of work.

Ensuring services can be provided remotely, from the pharmacy, means there is less need for provision of services off the pharmacy premises.

Alongside the potential benefits of increased flexibility for the workforce, would there be any unintended consequences for the pharmacy network?

- Need to consider the capacity within the pharmacy team;

- The potential for pharmacist provided services to be provided by individual pharmacists or other providers employing pharmacists; and
- The ability of all contractors to provide services beyond their local area would potentially damage the control of entry process.

Flu Vaccination in 2020-21

What changes are required to the service requirements or the practicalities of provision of the service to allow it to be successfully delivered during the pandemic?

- Availability of appropriate PPE (and funding for this, if it is not freely available via the stockpile);
- Any increases in the time to provide the service during the pandemic should be reflected in the funding;
- Flexibility of hours to allow focused provision of the service;
- Provision outside of the consultation room, e.g. in the general retail area of a pharmacy, and outside, but within the vicinity of the pharmacy;
- IT equipment and infrastructure needed for provision of the service outside the consultation area;
- Additional funding for home provision of the service for Shielded patients; and
- Patient-facing IT systems to allow appointment booking and the completion of pre-vaccination questions in advance of patients arriving at the pharmacy.

What other issues need to be considered in relation to the service this year?

- Provision of the service to Shielded patients;
- Be aware of staff objections to giving it – how can we tackle?
- Adding the pneumococcal vaccine to the service;
- Enabling pharmacy technicians to administer vaccinations; and
- Ability to vaccinate children that miss out on vaccination at school.

Summary of points from discussion session 3 (21st May 2020)

During this final session, the Committee sought to identify actions and priorities based on the discussions of the previous two sessions.

The following questions were used as prompts for the discussion. Key points from the group discussions and the points raised in the agenda paper are detailed below.

1.What are the five priority actions for PSNC right now?

a. 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.

b. 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.

c. 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.

d. Flu vaccination service 2020

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.

e. 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.

2. What is the top priority

A combination of the first two priorities: getting certainty on the funding for the remainder of 2020/21 will provide the platform for re-setting or resolving the CPCF for 2021 and beyond (tactically operationalising the current contract in the light of COVID-19). In parallel pushing for an increased contract sum and agreeing how that will be re-distributed

3. Comment on approach, attainability and any other considerations.

a. Need to build on the momentum from COVID-19 work.

b. Need to make politicians but more importantly, top officials, understand what pharmacy has been doing and its value to communities. Perhaps running a strategic stakeholder influencing programme covering NHSE&I, DHSC, HMT, MHCLG, politicians and the public.

c. Make sure our views are represented in the expected post COVID-19 review.

d. Gather case studies to show how pharmacy overcame challenges and continued to evolve as we reacted to the developing outbreak.

e. Being sensible about what can be achieved for the remainder of the year with a view to considering the likely capacity (GP view on flu will be key for example).