# Pharmaceutical Services Negotiating Committee Funding and Contract Subcommittee Minutes

**Zoom virtual meeting held on Wednesday 3rd February 2021 at 13.45pm**

**Items are confidential where marked**

**Members:** David Broome, Peter Cattee (Chairman), Jas Heer, Tricia Kennerley, Margaret MacRury, Has Modi, Garry Myers (Vice - Chair), Bharat Patel, Adrian Price, Anil Sharma.

**In attendance:** Richard Bradley, Prakash Patel, Mark Griffiths, Stephen Thomas, Sunil Kochhar, Mark Burdon, Janice Perkins, Niamh McMillan, Clare Kerr, Reena Barai, Sian Retallick, Samantha Fisher, Ian Cubbin, Jay Patel, Umesh Patel, Indrajit Patel, Sue Killen, Simon Dukes, Mike Dent, Jack Cresswell, Suraj Shah, Rob Thomas, Michael Digby, Sarah Welbourne.

1. Welcome from Chair
2. Apologies for absence

No apologies were received.

1. Declarations or conflicts of interest

 No conflicts or interests were declared.

1. Minutes of last meeting and matters arising

 The minutes of the meeting held on 20th November 2020 were approved.

**ACTION**

1. Remuneration

	1. 2020/21 contract sum forecast out-turn

The latest projected volume outturn for 20/21 is significantly lower than the previous year.

A consequence of this low outturn is that we would not receive any benefit from the ring fenced £24m HMT funding that was put aside to cover vol increase due to C-19.

Volumes for existing services (MUR, NMS etc) appear stable with previous expectations. New services are harder to project as we have little data to go on but currently included in outturn forecast at £12m.

The overall outturn projection is for a shortfall of approx. £28m in year.

A committee member noted that based on their own data they felt the outturn may be even lower than we have projected, especially January, so the shortfall could be up to £40m.

It was noted that there is a significant difference in the number of items for August this year and last year – we understand that monthly volumes can fluctuate and so work on a dispensing day basis.

The total spend for SSPs and AURs is extremely low so in the table they round to £0m.

It was noted that GPs may be prescribing less currently due to seeing less patients and doing other things such as vaccinations – if pharmacy starts taking on the vaccination burden then may also lead to a reversal in prescribing decline.

NT have discussed the potential shortfall in CPCF funding delivery including the extent to which we think it is real and what possible mitigation we should seek. NHS’ desire to separate fee and service reconciliations was highlighted.

* 1. C-19 operating cost survey
	The overall impact table to the end of November was noted by the subcommittee. The financial impact of the second peak was (so far) much lower when compared to the first peak, although the ongoing run rate of £15m per month is significant in the context of the annual £2.592bn funding.

December figures were shared, as these had just been finalised and totalled £15.1m for the month. The mix had changed, with ~90% of the impact being transferred costs as a result of reduced OTC and LES activity meaning the need to spend directly on staff was dampened.

Incremental non-staff costs are also relatively low, primarily as PPE is increasingly provided through the portal to many respondents.

In questions the building of cost in untaken staff holidays was highlighted. This is within the ‘non capture recognition’ and has been highlighted to DHSC as a major concern.

* 1. C-19 primary care contractors’ payments
	The information was noted and will be updated for each FunCon on an ongoing basis to provide background for negotiations.
	2. C-19 home countries’ payments
	It was noted by Mike that the information presented on Northern Ireland should be considered as WIP and that we will be meeting with CPN to clarify some figures.

As requested by NT we have also started gathering data on payments per head of population across the 4 home countries.

There were general comments from the subcommittee that the apparent large gap in funding support between the rest of the home countries and England was very concerning.

The office was requested to investigate the different payment levels between the different primary care contractors in the other home countries.

* 1. Services flat payments

Mike stepped through the paper on service flat payments. This covered broad objectives and what we could seek to achieve for each, along with some illustrative payment designs. The risk around the significant sum of unallocated funding was highlighted.

It was noted that when Monitor have previously looked at this issue of payments to NHS contractors, they have supported the idea of capacity payments, and Simon Stevens has recently stated that there needs to be a buffer / spare capacity built into the NHS.

It was noted that although we have used the current Transitional Payment bandings as a reference for the illustrative payment designs, originally these were said to be a temporary mechanism and that long term we would seek to move away from items-based funding distribution. A committee member noted that the payments based on patients not items would be more equitable due to various factors that affect income such as differences in PoT / prescribing habits.

A query was raised about long-term prospects for TP. MD explained that this had only been guaranteed until March 21 but we have stated to Govt that it needs to continue. The planned savings and transition of funding into services hasn’t happened for various reasons such as C-19 and lack of opportunities to reduce dispensing cost. Re-badging some of the money as capacity / service payments was a way to help secure some of the funding.

There was a general sentiment that capacity payments would help to alleviate funding distribution concerns due to uneven rollout of 3rd party dependent services. We need to seek a reasonable weighting between paying for capacity and paying for activity.

* 1. New funding models - verbal update

An update was provided on the work ongoing on the New Funding Models.

1. Reimbursement
2. Category M January 2021

The information in the agenda was noted. We had asked DHSC to leave in place the uplift in the DT from October (£5m per month) as DHSC had calculated a significant decrease in underlying market prices that would flow through into the DT.

In practice the DT increased significantly in Jan 21. This is helpful in the short term (given Brexit) but could lead to longer term issues if this contributes to excess margin.

1. Margin update

The agreed Q1 outturn is in the region of £160m and the preliminary Q2 figure appears to be in the region of £250m so we are roughly even after H1. However, run rates going into H2 look high given that prices have continued to decline according to buying group data.

Currently we are projecting excess over the allowed margin for the year.

As per the quarterly margin survey process this means we would expect to see declines in the Jul and Oct DTs. This could coincide with any C-19 advance repayments that we are required to make.

The NT has considered this within the context of our C-19 impact figures

**REPORT**

1. General funding update

The information in the agenda was noted. Mike explained the analysis of net change in contractor numbers is relatively robust, however getting more granular analysis within that is trickier. There are a few different sources of data available for number of contractors such as LPC stats / monthly dispensing contractor stats from NHS BSA as well as a quarterly contractor data set published by NHS Digital, which all give differing numbers of contractors.

The data set we refer to for analysis is the NHS Digital list, as it includes opening and closing dates for each contract, meaning we can use these dates to estimate how many pharmacies are open during a given month. As this number has declined over time, this gives as our net reduction in the overall number of pharmacies.

We struggle to determine how many ‘true closures’ there have been as the data set doesn’t flag transfers of ownership or mergers. It also doesn’t flag type of contractor. We use the contractor ownership code within the data to estimate which contracts are parts of groups; however, we know that some pharmacies within groups do not share the same code in the data, so this is only a rough guide. We also cross reference against a list of DSPs we obtain via FOI request from NHS BSA.

The data set only includes the current state of each contract so if it has changed ownership / name / owner code this change isn’t shown. We can look at address details for each pharmacy and try to match post codes / address 1st lines however we have found that these are not written consistently within the data so do not always match even when they are the same premises. We are also aware the data set seems to include some pharmacies which appear to open and close within only a few days; these might be intermediary steps in a change in ownership.

Given the various anomalies in the data any granular analysis can only be an estimate.

1. Statistics

The information in the agenda was noted. The recent uptick in reimbursement per item for dispensing doctors was highlighted.
2. Any other business

None