Minutes from Community Pharmacy Arden (CPA) meeting 12th Jan 2023

Chair: Faye Owen (FO)

Members in attendance: Jas Heer (JH), Bal Heer (BH), Faye Owen (FO), Theresa Fryer (TF), Sat Kotecha (SK), Sam Griffiths (SG), Mike O'Donnell (MD),Caroline Harvey (CH), Baljit Chaggar (BC), Adel Ghulam (AD)

Support Office in attendance: Eva Cardall (EC), Fiona Lowe (FL), Zoe Ascott (ZA)

Guests in attendance: Dr Andrew Warner (AW) of LMC

Apologies: Altaz Dhanani (AD) of ICB

1. Open DOI, Minutes, Market Entry, Matters arising and Action Tracker

2. Transformation Proposal

3. PSNC Update

4.IPMO

5. LMC

6. Services Update

7. ICB Update

8. Workplan Priorities and Frequencies of Meetings in 23-24

1. Open DOI, Minutes, Market Entry, Matters arising and Action Tracker

FL: SK will be late. ZA will be with us after lunch. EC will be taking minutes.

FL: Any comments about minutes please send those to ZA. Market entry we have just had something come through, one in Warwick has been approved on appeal. ZA will update later.

Action Tracker: Lists of emails and back-office numbers from surgeries still a struggle. LMC also need to follow up with them on one pager that all were meant to send (Optom, Dentists, GPs and Pharmacy) only LPC for pharmacy sent through their part.

FL: Constitution updated and approved by all – through PSNC including AIMp Members. Mike separately confirming through AIMp directly. MD yet to read the revised version circulated some time back and on Box.

FL: Any AOB or matters arising to raise?

CH: I wanted to pick up about Diphtheria and Antiviral service with Taz

2. Transformation Proposal

FL: (Shows November TARP document) This is what went out to contractors after last meeting. There won't be much to change to this for the SGM voting. This is how the PSNC want us to format the name 'CPX' and how they want to us to be organised. We are not far off the 200 per CPX. We are

only asking to accept the constitution. We don't need to increase levy. We don't need to elect a committee as we only formed April 2022 following merger for a 4 year term. We have our SGM set for the 9th Feb. The intention is to send out the tidied-up version of this along with voting papers as per PSNC on Monday 16th January to give as much notice as possible. Is everyone ok with this? We haven't had any negative feedback. Action

FO: It is quite clear to see and I'm happy with the format.

FL: The Constitution. I know this is one of the CCA questions. This is the updated constitution (shows document) as per PSNC, the bits in yellow are the parts we need to change. The names haven't changed from our last constitution. The Health and Wellbeing boards is also in yellow as is the ICB. The next bit is about a balance on committee in relation to Warwick and Cov. The next part is Term of Office. Ours started on 1st April 2022. We don't need to change it until 31st March 2027. HW however, will need an election.

MD: As a consequence of what's happening in the midlands with one big company branches in particular, how is that going to be taken account of in terms of the representation?

FL: It won't make any difference for us as when we set the terms of a committee as it is based on the 31st October 2021 prior to when we held our election in 2022. If an individual member changes type, say from Aim to CCA etc then they may need to leave etc and a suitable representative from the original group appointed / elected.

Discussion ensues regarding the balance of representation on the committee considering that multiples are selling branches and as a reps are moving from CCA, Independent and AIMp, possibly needing to resign their position on LPC and potentially the set ratios of members not representing the overall CP population.

FL: 90% of LPCs will need to go through election process. What PSNC are deciding on whether the 31st of October is still the right date to be decided or if the 31st January is better. So that's what we are waiting for. In HW it will make a difference. As we already exist (CPA), and we are based on the status as of Oct 2021. We are having a year added to it to make it five years total. We don't have to change our constitution but are choosing to do it now. We just want to tag on a year. The committee is already in post.

MD: It was not foreseeable, but we may end of with a committee that is not proportionate with the representation of pharmacy types.

FL: JH, you don't know when they [the PSNC] are going to decide on cut-off for elections

JH: No. *(later confirmed as 31st January but not apply to CPA)*

FL: We could see a big change in a short period of time which means the representation model as of the 31st of October would be completely off and I agree it's just a bit strange but it's just the way it is.

FL: So the transformation that we need to share is: Constitution, we will update the proposal that we sent out in advance, it will only be tweaks, PSNC and CCA are both happy so we would expect that vote will come back positive. Remote voting must be in by 12 noon, 7th Feb – vote ahead of the SGM on 9th 7-8pm. We must be quorate, but additional people need to ask for the link and then we will share it.

FO: Yes, the presentation on Box was also good.

FL: Is everyone happy with this transformation information. Mike, are you happy from an AIM perspective?

MD: I don't know yet, as I'm waiting back on response on a query that I put in an hour ago but hopefully it is approved.

FL: Ok well it will be sent out on Monday so have until then to lodge any concerns. Going back to the agenda. As AW nor AD here for LMC and ICB parts we can go to a different section. JH, would you like to cover off the PSNC?

3. PSNC

JH: Following on from the transformation discussions, the PSNC Committee is being reduced in size to **24 in total – 10 independent, 9 CCA, 3 AIMp and 2 NPA**. It appears that we will have two reps in the Midlands overall which tends to sort align with NHS structures. The election for the reps process has started and everybody who's entitled to stand as an Independent Rep should have been notified by now, that's over the whole patch. An expression of interest must put through if you want to stand by the 30 January and then 8th Feb for formal nominations. If there's more than one person who wants to stand there will be in a ballot and what we're trying to do is to make sure that the rep is in place for the 1st of April. West Midlands region is smaller thankfully so a fewer ICBs to look after for the rep. So, if anyone knows any independents who would be interested in this role please encourage them to apply. PSNC Regions West Midlands = BSOL, CPA, CPHW and Black Country ICBs (4 merging / federating LPCs). East will be LLR, Derby, Notts, Lincoln, Shropshire, N&S Staffs (NHSE Regions West = 4 + North 2 ICBs and East the remaining 4)

4. IPMO

SK: My role with IPMO will be moved into ICB. There may well be that there is no role in ICB for my role. The funding for my current role is a 20K budget. It is difficult to extract this money. It is possible that my NHS role will not exist. It will beg the question around representation. How we will get good representation at both levels. A few things to talk about today is that NHS have sent out some funding to set up an academy for pharmacy. Sumara is leading this work etc. It is essential. It is our job as an LPC to get IPMO to work. We need to move from conversation to action. We need to push. 120K IPMO unspent in workstream.

FL: It's very acutes focussed as well and haven't got the 8c role in place yet. I will be interviewing with Mark. Some other areas have only had one applicant.

JH: From a PSNC perspective, any overspend on services will be clawed back from services etc. We also must look at our capacity to do extra services.

FL: It is very tricky at the moment. The 120k is there in the ICB. AD is saying that they don't have any money to support GPCPCS, antiviral, palliative care etc.

SK: We need to look at how we increase recruitment into CP and not into GP. There are some of the questions we need to ask. If you want us to deliver GPCPCS/BP etc then leave our workforce alone. It is a bigger conversation which is why IPMO is so useful. It is sad that it hasn't gained more momentum.

JH: Nationally it is still their policy, the workforce [to recruit pharmacists into GP surgeries] but they don't need more pharmacists to essentially do admin roles in GP surgeries, hopefully this message has resonated at a higher level now.

FL: The thing that they are pinning things on is around the IP status in CP.

SK: In community pharmacy, national PGD led services would be right to set up and then not use the PGD side when you become an IP and competent in the given area.

FL: They will pay for the pharmacist's time per session. Each ICB will be looking at this. I've got agreement from AD that we can get another seat on the ACP. Which will hopefully be EC.

AW has arrived. AD has sent his apologies.

5. LMC

FL: AW, would you like an introduction to everyone?'

AW: No, I think that I know most people.

FL: Well, one was a follow up to our meeting at the Rugby club and where we have with that and representation in general and how we are all feeling and Maggie was wanting to talk about Labour's plan for GP, Supply chain, GPCPCS, SSPs etc. Anything else you wanted to discuss?

Should we start with the meeting where we all met and were going to do a one pager from all.

AW: Waiting for the one pager from dentist and optometrists.

FL: Maggie was saying that she wanted it in two lots. First lot, to all work together and understanding how the provider board etc works and getting representation. Our contracts will be moving over in April and then what we can collaborate on.

AW: hopefully not much longer. We are equally eager to get it out.

FL: IPMO works well sometimes but not always. Maybe if we look at how the SSPs went or didn't go and then maybe look at care homes with antivirals etc.

AW: Strep A has been chaotic. We are anticipating another spike in concern after the return to school. There will be a lot of contacts in next week or so.

FL: Supply chain wise, has that eased or still pen V a nightmare?

SG: Pen V still a nightmare

FL: The SSPs still in place until late January. Concern about February particularly considering AW concerns. Has the SSP helped ease things, reduce the pressure on GPs to scrabbling around to find stock?

AW: Yes, I believe so. Terry would know.

TF: Clarithromycin has been the problem.

AW: it's a problem because it is sometimes better than the pen V so it is necessary to write a script specifically for it.

FL: The communication of drug changes within 24 hours using SSP as required, has that caused any issues?

AW: no, no noise.

FL: Antivirals, nobody has enough, and no one can order enough for one whole care home so it's a matter of running around looking at who has what.

AW: Yes, one pharmacy holding stock in each locality is useful

FL: the stock holding may not be enough. Has anyone else had any issues with stock holding of Tamiflu?

AW: we used to have a steering group, but we haven't had one since covid. So haven't adapted plan.

CH: Stock holding isn't the issue. Its more the issue about how the script is sent. How long it takes.

FL: If it is your patient, it is easy. If it is a care home patient, then it's not going to belong to your pharmacy, so they need to be found on the system and this is where the issue is. From the pharmacy perspective.

CH: Its incredibly time consuming.

FL: Proxy access might be a solution

CH: Can the surgery send a list of script numbers? It's a whole long job of searching on the spine. Is there no way of doing a one-off send as a one-off to a pharmacy

AW: No, there isn't. This would help us. The simplest way might be to change nomination and then remember to change it back 24 hours later but there are risks with this also.

BC: There is a way to copy and paste to word from Emis.

CE: Yes, that is useful.

FL: It might be worth having a look at Emis. Action

AW: I'll speak to my admin to see if we can sort something out. Action

FL: Two things left on my list: How do we get hold of these golden emails and phone number, HC professional lines that pharmacists can use?

AW: Most of us are happy to give them out and if we can get them from all then we can send a list. Standard email is still the best one to email.

FL: The principle has always been, don't share this information. We are going to have a database of contacts that is password protected that only contractors can use and access only the appropriate lists of numbers.

AW: Surgeries don't share these numbers with each other either and the consultants at the hospitals are eager to get them too.

FL: Any progress on this would be great.

SG: I thought there were numbers on Service Finder for direct access?

FL: It's about all the numbers in the correct place on one list that can be maintained.

AW: The problem we have had, the surgeries have had an issue with leaking out of numbers.

FL: Yes, I understand. We just need them to be able to make direct contact to provide services efficiently and properly. Anything you can do to move them along here.

AW: I am trying, as I said the consultants are also looking at this.

FL: Only thing left is GPCPCS, if it is done well then patients can be seen more quickly etc and it is seen as the way to 'save the world'

AW: I think it will pick up more and more and more.

CH: Was talking about this with the surgeries, that they cannot see the reasons for rejections. If we look at this when we visit surgeries, then we can look at what they can or cannot see. Action

FL: not all the information goes through unless its in the comments sections. It looks like an empty referral. Action

AW: I will check in with our admin team, it seems crazy that we can be having duplication of entry.

[EC provides brief overview of the numbers of GP-CPCS in the area and the increase over December, common misunderstandings, and the CPA plan to improve pharmacy delivery (as per later presentation shared on Box)]

SK: We have talked about GPCPCS, what do you think about Hypertension services, AW? Action

AW: I just know the levels for urgent referral are too low for pharmacy.

SK: Personally, a clinic reading in a pharmacy is better than a home reading. I think this is something that a pharmacy can really support with. I think it's a missed opportunity. Its an important collaboration.

AW: Lots of people don't have home BP monitors and equally useful to get home BP measures checked in pharmacy.

SK: I looked at Shape Atlas its 4-5K patients in each PCN need a BP reading. Good for pharmacy and good for GP.

AW: I have no problem with the service. Our worry is the referral to AE and the levels this happens with CP service.

SK: the levels are changing. This would set a good place for future collaboration.

AW: It is also true that we can take the appropriate action even if pharmacy levels indicate to be seen immediately.

FL: Some pharmacies have done a lot but some not at all. We are hoping the new levels come out before more start to do it.

AW: We have the Pharmacy Hub in Leamington. Directing more people across to the Pharmacy Hub would be helpful. We could communicate this to PCN directors.

FL: I suppose the only other thing is the stock holding of palliative care and your view on this. Or if it is something you could go away with and ask. Action

AW: Locally we have tried to standardise the directive so the same drugs are being used and can be easily sourced. How far that stretches within the patch I don't know but in our area, it works quite well and patients/DN can access the medicines easily. Bath street is our go-to for supply.

TF: yes, we keep good supply.

FL: Anything else from anyone else.

AW: We will get back to you as soon as possible. We will push all the above.

6. Services Update – EC

Please see slides on box. Group discussed. 1. GP-CPCS referrals from pharmacy and GP perspective, NMS, Blood Pressure, Discharge Medicines Service and Other Services and projects. The useful points discussed were thresholds for BP payments, how many ambulatory to expect and why and that Depression was being pushed back as a condition for NMS.

-Lunch Break-

7. **ICB**

FL: Let's discuss where NHS England is with this move to ICBs. Should mean more resources should be available to us. Some of NHS England's activities will be managed under a host ICB. Who is it for the West, SK?

SK: Birmingham we think but has not been announced.

FL: They will still do some of the things that come under regulatory aspects and fitness to practice etc, certainly in the short term. On Mapcog on a Tuesday, gradually more and more ICB people are on it with less and less NHS England people. We don't think rota is moving to ICB but staying with NHS England. The other things are the PGD services which all run out at end of March. They are going to try and cleanse that list. They have persuaded all the ICBS to take it on for another year. They are looking to increase the number of tier 3 pharmacies. Lots of complaints about rota. No such thing as fair share around rota. They are based on geography of need/supply. The only two they can direct for are Christmas day and Easter Sunday. They are going to be discussion around fees for rota opening. £390/hr in Wales in comparison to here [where it is much lower]

SK: It works as a disincentive for pharmacies to be in that 'sweet spot' and signing up for critical services like palliative care etc. It's not fair. We discussed a soft expression of interest pre-direction.

FL: I totally agree but 'fair share' is not in regs. Action follow up re ROTA

8. Workplan Priorities and Frequency of Meetings in 23-24

FL: The two bits we have left are 1. What the priorities are and 2. When should we meet and with what frequency. Let's start with number 2.

Following a discussion, we agreed: some online, some f2f. If you work in pharmacy, you will need a whole day back-fill. Sometimes we don't need a whole day. Workshop type meetings work better f2f. What do you all think? I have said 5 /year rather than 6 so that we can use one slot to have a workstream day where we stay until we finish the pieces of work allocated. So overall not cutting down the number of days but changing the format of one. Also, if we have a half day meeting then we use the time in the afternoon, that we are being charged back for, to do other LPC work.

SK: Some work is not possible to complete work in a set day. If we can assign work and take full responsibility of that work and own it thereafter, putting in whatever is needed to complete it.

FO: I agree with this policy of ownership and planning. Need to think about value and content.

FL: To manage all expectation I'm thinking about having it as one day rather than small parts.

CH: I prefer this advanced warning and task in advanced and then the day to finesse it.

FL: We could have this day linked to AGM day. We don't need the November meeting. Then we have right through until the January to complete. September meeting with half day allocation to next meeting then an October Workstream meeting. Action – Fiona to plan next 12 months of meetings and Autumn will be the strategy and workshops f2f session

JH: The timing works well. Typically, we plan for next year in Oct/Nov.

FL: Definitely f2f for October meeting. Ok agreed. What is the consensus on f2f or online generally.

FO: We have a mix in the plan.

FL: Do we want f2f or all online meetings or a mix?

SK: Alternate is reasonable. Hybrid doesn't work. Do we need to be f2f all the time? Probably not.

FL: Alternate with flex is the best approach. If they are half days and you are going to charge for full day then we can use extra time for other tasks. We will timetable it into the agenda.

FO: Have you got any hotels booked going forwards?

FL: no, not yet.

FL: The other bit was to look at the top three other things to be looking at. I've put as a starter – supply chain, advanced services (as on agenda). Is there anything we should add into our list.

TF: Supply Chain we can talk about but we can't do a lot about. Advanced Services is probably the most relevant. Oral contraceptives.

FL: Oral contraceptives being postponed now until March.

FL: External Engagement is an area we need to work on. 1. Advanced Services Implementation 2. Contractor Engagement – new ways. 3. Workforce and all things local to do with ICBs.

SK: Need to make sure we communicate all things clearly and targeted at the audience.

CH: Need to collaborate with PCN pharmacists.

FL: are we all happy with these three?

All: yes.

FL: CCA questions. Let me have a quick look.

FO: All done.

FL: PQS information has improved hugely on PSNC.

As Zoe is leaving, we are changing the way we do things. Market entry, I will need your help with this – unless you are conflicted.

JH: Do we need to cover the one that was granted on appeal.

FL: yes

ZA: It's on a housing development in Warwick. Discussed in November. Vickers Way Warwick. New housing was reason. Another appeal come through for Houlton. May set a precedent. I will put document on Box.

FL: It refers to the old PNA as new one hadn't been printed. Interesting decisions.

Comms will also be a bit different from mid-Feb. Fortnightly general local comms, services comms every two months or every month depending on need. We are also going to try to direct all to ahwlpc gmail. Will still be responding to others. We are going to try having a reply email on ahwlpc saying that we will reply within two days.

Finally thank you to Zoe and we all wish her well for her maternity leave with new baby girl in February.

-----Meeting ends ----