CPA – Minutes from Meeting Thursday 9th March 2023, Holiday Inn, Coventry.

In attendance: Adel Gulam (AG), Jas Heer (JH), Faye Owen (FO), Satyan Kotecha (SK), Mike O'Donnell (MD), Baljit Chaggar (BC), Fiona Lowe (FL), Eva Cardall (EC).

Sam Griffiths (SG) attended remotely via Teams.

Apologies: Theresa Fryer (TF), Caroline Harvey (CH), Bal Heer (BH)

Guests: Tim Sacks (TS)- Director of Primary Care, Altaz Dhanani (AD) Deputy Director of Medicine Optimisation. ICB Coventry and Warwickshire.

10am – Meeting opens.

FL: Ways of Working has been updated, overall it remains the same The accountant will be in the office on 19/03/2023. It is only necessary for treasurer to attend and it is just the levy information we need them sort, which we will explain. Nobody else needs to attend but they are welcome to if they so wish.

We have guest today Tim Sachs from ICB. We should discuss as a group what we might like to ask him before he arrives.

SK: The National Global Sum has run out. This means that any additional National service provision eats into our dispensing payments. We need to maximise profitability from dispensing. We need more local services and I want to raise this with ICB.

MD: ICB have limited influence over such things. They can bring in prescribing guidance that does impact us – so would like to raise that with them. Also, we need them to stop recruiting our staff at general practice level.

FL: Would be useful to raise the issue of HRT scripts and that with the new pre-payment these need to be on separate scripts. Also, issues with supply chain, vulnerable patient funding, function of virtual wards and how these patients get their medication.

SK: Yes, we need more funding for things like MDS and delivery. While we have the infrastructures still in place, soon nobody will be doing this for free and it will be too late to start up for a fee.

-Guests arrive-

LPC in attendance introduce themselves to TS and AD

TS: (gives brief summary of his previous roles) ICBs are in their infancy and still quite disorganised. Within three years there won't be commissioners and we will be charge of all SRO. ICB have little influence over national contracts. National team are entirely clueless – a lot of imposition with very little thought behind it. We have a 120m deficit, most created by inflationary pressures and not by poor management. We really need to come together a bit differently across GP and pharmacy, the strange relationship that exists between the two is not conducive to effective working. I would like to understand from you as an LPC, firstly how do you view the NHSE contract, and secondly, what opportunities you think there are.

FL explains why a separate script is necessary for HRT when patient avail of the lower cost pre-payment certificate.

SK: A solution to this might be eRD for all HRT.

SK: I see a big opportunity for pharmacy to do all the BP checks and feed it straight back into the patient record, but we need full integration for this to work well. The need for patients to be redirected to pharmacy for CPCS rather than pharmacy being the first point of contact similar to the funded 'Pharmacy First' model in Scotland, doesn't make much sense. We should be able to claim for patients that we have taken out of the GP workstream. We are doing a lot of things unpaid – deliveries, dosette trays etc. We are under a lot of pressure and our funding is very tight. Many have stopped doing things like deliveries and dosette trays and this puts a lot of pressure onto Social Care. Although their guidance does not advise the use of trays, they have come to rely on them as a means of spending more time with the patient within the limited window they have. The question must be asked, how can we enable pharmacies to continue to support with these things.

FL: The number of patients that are back in hospital six weeks post -discharge is worrying and the capacity for pharmacy to help support these patients is shrinking. We are propping up social care and historically have compensated for their lack of training. We have even supported care agencies with training in the past.

SK explains guidance document that states that dosette trays should not be used routinely in patients with carers. He notes that this has guidance has not reduced the demand for them.

SK: We would like to support better integration which would support pharmacies with delivery of services. Clearer pathways for patients with reduction in number of referrals in from third parties.

TS:

I have four priorities that I have been given:

1. Access to GPs
2. Maximising ARRS roles
3. Dental Activity
4. CPCS

MD: The pharmacist went over to the surgery to speak to them and support them in working out how to get things moving. We have kept good level of referrals and managed them well.

TS: We get pushback from GPs saying, 'no point in sending them, they are only sent back' and your example tells a very different story about referrals.

SK: All the money for GP-CPCS comes from global sum.

TS: So, a 10x increase in GP-CPCS doesn't actually get you more money

All: that is correct.

SK: How pharmacies manage an increase depends on how they are set up. Realistically a small pharmacy could manage two referrals in the morning and 2 in the afternoon with the rest of the workload of the day. They need to be good referrals though.

TS: We are a very small team at the ICB, team of 6 to do everything, there have been significant management cuts in the ICB also. I have RAG-rated all the objectives, and most have been put at R. I need the contracting team to put a plan together for pharmacy. I will have a team of four and one will focus on pharmacy.

MD: Strategy is very important to consider, it isn't just processing numbers and contracts.

TS: Additionally, I do think it would be worthwhile for me to lobby our CMO to have a funded person for strategy in pharmacy, supporting the 8c role. Currently, it will be me who writes the 5-year strategy, there isn't anyone employed in this capacity.

TS: IP plan sounds great as it improves patient access, decreases inequalities, and increases capacity across the system. It does bring us back to the key issue of improving the Pharmacy and GP relationships. Integration is necessary to ensure surgeries wont loose credits for any work pharmacy picks up for them.

FL: It is important to mention that from 2026 all pharmacy graduates will leave university with an IP qualification. Legacy workforce, need to be trained and sponsored.

TS: Primary Care Collaborative needs LPC representation. For money to go into pharmacy the pathways need to change, and we need to see overall system benefit. Action: TS to get LPC represented at PCC.

-Lunch-

Post lunch we had services presentation by EC – shared separately. Discussion around services not being picked up by contractors within the timeframes allowed – mainly DMS accepted within 72 hours but also GP-CPCS not being picked up either. Agreed that some pharmacies were undergoing ownership changes now or in the future and staffing issues meant services wouldn't be a priority. Reminded LPC members of the DMS event on 28th March and also about the GP-CPCS Webinar for surgeries.

3.30pm – meeting closed.