LPCs

September 2017

PSNC Briefing 073/17: LPC size and structures – a discussion paper for LPC meetings

This PSNC Briefing has been created to support LPCs in adapting to the current climate in community pharmacy and wider healthcare. Here we have outlined the important role that LPCs play and their priorities going forward, which leads on to some recommendations for the expertise and structures which will be of most benefit. PSNC hopes this guidance will help inform LPC discussions on these issues.

Background – the need for strong LPCs

Once again, the NHS is undergoing radical changes, and this includes the realignment of local commissioning structures. Many of the changes flow from the NHS Five Year Forward View, and they include the development of Sustainability and Transformation Partnerships (STPs) and Accountable Care Systems (ACSs) and Organisations (ACOs). The impact of these changes on local commissioning and the local providers and representatives involved in it cannot be underestimated. Community pharmacy contractors more than ever need strong local leadership from their LPCs, making sure that as local commissioning changes, pharmacy is part of the new pathways from the start.

Alongside these structural changes, the health and care system is trying to find new ways to manage the immense financial and demand pressures that it faces. The unsustainable pressures on GP services mean there will be opportunities for other healthcare providers to do more — LPCs must make sure the right people understand the benefits of community pharmacy and the services the sector can offer as part of an integrated approach to care.

This need for renewed work with, often newly appointed, local commissioners comes at a time when contractors are being hit hard by funding cuts and are coming to terms with changes to the Community Pharmacy Contractual Framework (CPCF). Unsurprisingly, LPCs report that their contractors are increasingly looking to the LPC to provide them with more support, implementing contractual changes such as the Quality Payments Scheme and supporting local and national service provision, such as the Flu Vaccination Advanced service.

Both these demands on LPC resources mean that many LPCs have been considering how they can work more effectively, providing more contractor support and increasing engagement with commissioners, without increasing the levy. As part of this, a growing number of LPCs have already reviewed their structures—merging, federating and working together more collaboratively—making sure the organisations have the expertise and resources to work effectively for their contractors.

This discussion document is intended to help LPCs to reflect on their priorities for the remainder of 2017 and beyond, and then to consider the expertise they need, and the optimal structure and size of the LPC to deliver the programme of work. The document concludes with questions to prompt discussions at LPC meetings.

LPC priorities for 2017 and beyond

Following discussions with a number of LPC Chief Officers, the below priority areas have been identified as being common to most LPCs. From those discussions, it is clear that there is no one size fits all approach to aligning LPCs with the current local NHS structures and LPCs must adapt to the local situation. For example, in some areas the STP is not yet playing a major part in influencing local commissioning and so LPCs need to develop their relationship with STP leaders, whilst maintaining their relationship with CCGs, where commissioning decisions are still being taken. In

some areas, a place on an STP board is important, but in others this is not the case, with influence being more impactfully applied at a lower level within the governance structure. However, in the absence of a place on the STP board, LPCs have found that it is important to have a board member sponsor to speak up for community pharmacy.

The transition of STPs to ACSs and ACOs will take place at different speeds across the country, but the increasing importance of the STP in comparison to the constituent CCGs is increasingly being manifested by mergers of CCGs, or more frequently, moves to common senior management teams across a group of CCGs. The future of CCGs is therefore unclear, but they continue to be the commissioning organisation for most NHS services in their area for the time being, even if decision making is taking place across a wider geography. This means that LPCs need to maintain relationships with CCGs, while keeping a constant eye on changes at STP level, including the development of GP federations and other organisations which may be the starting point for the development of an accountable care provider.

Essentially, LPCs will need to concentrate on the big structural changes within the NHS for the next 3-5 years, making sure the committee is geared up and aligned to work with the emerging organisations. This will require careful planning. Particular challenges that LPCs will need to consider and address in their workplans will include:

Working with the evolving NHS structure

- *Horizon scanning and monitoring:* keeping up-to-date with organisational and structural changes within CCGs, STPs and other relevant organisations, so the LPC is ready to act and does not miss opportunities to engage;
- *STP relationships:* building relationships with STP leaders and ensuring they understand what community pharmacy can offer; gaining places on STP implementation teams/working groups, or potentially on STP Boards (but recognising that sometimes, more effective influence may be achieved at a lower level);
- *CCG relationships:* maintaining and, where necessary, building relationships with CCGs (including their medicines optimisation teams) as they continue to commission services and as they potentially merge management with other CCGs within the STP area and / or evolve to support the move towards the area becoming an ACS or eventually an ACO;
- *Working with other stakeholders:* maintaining and, where necessary, building relationships with other commissioning organisations, - local authorities, secondary care, the local NHS England team and any prime-providers for local services;
- *Patient groups:* maintaining and, where necessary, building relationships with organisations representing patients, for example, Patient Participation Groups and Healthwatch;
- *Working with GPs:* building an appreciation of community pharmacy's services offering with GPs to support closer working and commissioning opportunities, particularly at CCG, GP Federation and LMC level;
- *Working closely with NHS England's Local Professional Network (LPN)*; and
- *LPC availability:* having LPC representatives available to attend and speak up at key meetings (there may be many meetings which would be beneficial for LPC representatives to attend).

Contractor support

- *Support:* supporting contractors with changes to funding and meeting CPCF requirements; this may include the need for more pastoral care and one-to-one support with some;
- *Two-way communication:* making sure there is a strong relationship between the LPC and its contractors, so that contractors understand and appreciate the work of the LPC, the LPC understands its contractors concerns and support needs, and the two parties work together to achieve the best outcomes for local community pharmacy;
- *Training:* ensuring contractor training is available at appropriate times on relevant topics – consistency of training across the LPC area is important too; and
- *Commissioning work:* continuing to try to get local services commissioned and to try to prevent any decommissioning of pharmacy services. Or reductions in funding.

Communications and marketing

- *Local lobbying:* continuing to build on the campaign work to promote and protect community pharmacy by engaging with local MPs and Councillors;
- *Promoting pharmacy:* marketing community pharmacy to all local opinion formers and stakeholders both as part of the lobbying process but also more widely;
- *Media work:* engaging with local media networks to promote community pharmacy;
- *Communications planning:* ensuring that LPC communications channels including the website and social media accounts are effective, and that there is a proactive plan for communicating; and
- *Reactive communications:* ensuring the LPC has people available and a process for reacting to media queries or getting urgent messages to contractors.

All of this is in addition to the day to day administrative work of the LPC.

What expertise will an LPC need to deliver this?

A successful LPC will need people with:

- Excellent written and verbal communication, influencing and engagement skills (particularly important for governing body influencing);
- Strong clinical and project management skills, to develop and support the delivery of new services;
- A good understanding of the NHS and care systems, and of procurement, commissioning and contracting processes;
- Good administrative skills;
- Good social and people skills – (particularly important for multisite contractor visits);
- Financial management skills; and
- Management and leadership skills to coordinate and lead the team and to be accountable to the LPC.
- Strategic thinking.

A fundamental issue that many LPCs may still have to tackle is their employed staffing and staff development to enable all of this. The evolving health and care world requires more from an LPC than just a dedicated employed Chief Officer with administrative and service support backup is likely to be able to provide. LPCs must ensure future needs are constantly scanned and staff identified and developed. This is likely to require an ongoing staff development programme. LPC members also need to be available to help meet the challenges, and their skills developed to ensure they can contribute actively to meeting the LPC's objectives. At least one LPC is in the process of employing their LPC Chair rather than using an honorarium to increase the number of people of the right calibre to attend the highest-level meetings at any one time.

At this stage, some LPCs may say 'there is no way we can do all of that or have the funds to employ the staff to deliver it' but there are options that LPCs can consider to help them deliver on the priority areas.

What structures can LPCs create to deliver on the priority areas?

Alignment is important. LPCs must make sure that the LPC footprint fits with the most important local health and care commissioning structures – that may be the STP or another body; whatever is necessary for the best interests of contractors.

The first option is to consider merging LPCs. This has been successful in a number of areas, with Greater Manchester, West Yorkshire and Cheshire and Wirral being notable examples. However, merging may not be possible for some LPCs due to distances or other geographical factors such as the STP footprint.

Other LPCs, who have decided that merging is not the best option for them, have formed a single overarching team, creating a federation as such. This team has the necessary skills and expertise and is funded by and spans several

LPCs. For example, the Middlesex Pharmaceutical Group represents four LPCs: Barnet, Enfield and Haringey LPC, Brent and Harrow LPC, Ealing, Hammersmith and Hounslow LPC and Hillingdon LPC.

Other LPCs have taken a collaborative approach, working closely with neighbouring LPCs on certain priorities. For example, Hertfordshire LPC and Essex LPC are within the same STP footprint and have therefore worked together to make sure there is one unified voice for community pharmacy to the STP.

The LPC will need to consider what structure works best for contractors on a local basis; there is not 'one size fits all'. The main aim should be to create a structure, either through merging or other means, that has the resources to deliver the priorities identified above. This doesn't necessarily mean that all LPCs should have 600+ contractors (albeit those contractors have access to an LPC that can offer more support). However, an LPC must have sufficient contractors to provide the required levy income to complete the necessary work.

Once a decision has been made on LPC structure, due to the ever-changing healthcare landscape, LPCs will need to review that structure on a regular basis to ensure it is still appropriate and will still meet contractors' needs.

Size of the LPC committee

Some LPCs have reduced the number of committee members that they have, partly to save costs but also to have a smaller and more focussed and engaged team that can make sure the LPC operates effectively. It is for the LPC to decide (and the upcoming LPC elections is a good time to make changes) how many committee members it should have. However, fewer than 10 could make the membership too small to be properly representative and the LPC could be in danger of giving too much power to a small number of individuals. Thirteen is traditionally the number of members an LPC decides to have as a committee and an LPC with more than that number should consider reviewing to see if fewer members would work just as well if not better. Even if an LPC currently has 13 members it is still a healthy exercise to consider the pros and cons of changing this number.

Discussion points

Many LPCs will soon be holding their first meetings after the summer and will also be starting to make plans to elect a new committee early in 2018. This means itis a good time to have a discussion at an LPC meeting to make sure the new committee is fit and ready for the new term and has the resources to meet the growing demands on LPCs. Here are some suggested questions for the LPC chair or facilitator to ask to stimulate discussion:

1. Thinking as a contractor, do you agree that the priorities listed above are those that you would like to see the LPC working on? If not, why not? Are there others you would add?
2. Thinking as a contractor looking to an LPC for leadership and support in a changing and challenging environment, is the expertise listed above what you would value in an organisation working on your behalf?
3. Think now as a member of the LPC, can we deliver to a reasonable degree on the priorities listed above?
4. Does the LPC, to a reasonable degree, have access to the expertise listed above?
5. Does the LPC, on its own, match the STP footprint?
6. If the answer to 3, 4 or 5 is 'No' – consider if a merger or collaborative arrangement with a neighbouring LPC would be a possible remedy?
7. If not a merger, what other structural changes would reasonably remedy the shortcomings?
8. Think about future needs, the staff you will need and how LPC members can be developed.

Background reading

- PSNC's options for LPC restructuring and PSNC's LPC mergers checklist – both available from the LPC Members Area of the PSNC website.
- LPC Spotlight articles, in particular West Yorkshire, East Sussex, Thames Valley and Greater Manchester LPCs.

If you have queries on this PSNC Briefing or you require more information please contact Mike King, Head of LPC and Contractor Support.