PSNC Agenda

For the meeting to be held on 10th July 2013

at the Grand Harbour Hotel, West Quay Road, Southampton, SO15 1AG

commencing at 11.15am

Members: Stephen Banks, Dhiren Bhatt, Christine Burbage, Mark Burdon, Peter Cattee, Liz Colling, Mark Collins, Ian Cubbin, David Evans, John Evans, Mark Griffiths, Kirstie Hepburn, Elisabeth Hopkins, Tricia Kennerley, Andrew Lane, Margaret MacRury, Rajesh Morjaria, Andy Murdock, Garry Myers, Bharat Patel, Indrajit Patel, Kirit Patel, Rajesh Patel, Umesh Patel, Janice Perkins, Chris Perrington, Adrian Price, Alan Robinson, Omar Shakoor, Gary Warner

Chairman: Sir Peter Dixon

1. Training

A training session on the margin survey has been included into the agenda.

2. Apologies for absence

Apologies for absence have been received from Omar Shakoor.

3. Minutes of the last meeting of PSNC

The minutes of the PSNC meeting held on Tuesday and Wednesday 14th and 15th May 2013 were shared with the committee and can be downloaded from PSNC's website.

4. Matters arising from the minutes

To consider matters arising from the minutes of the May meeting which are not dealt with elsewhere within the agenda.

5. Chairman's Report and Chief Executive's Report

6. Update on the Health and Care Landscape

An update on developments of interest in the health and care landscape is set out in **Appendix 02/07/13**. Alastair Buxton will highlight points of particular interest.

ACTION

7. Election of RAP Member

Following the resignation of Ian Cowan, the Committee needs to elect an additional member of RAP. The Rules stipulate that the chairmen of the subcommittees and the Vice Chairman of PSNC shall not be eligible for election to the Review and Audit Panel.

Committee members (other than chairs of subcommittees or the Vice Chairman) are invited to put their names forward for election at the PSNC meeting, and should there be more than one eligible candidate, a ballot will be held.

8. Constitution Changes

Changes to the Constitution for consideration by the Committee are set out in **Appendix 03/07/13**.

9. Format of PSNC Meetings

At the PSNC meeting in May a few Committee members expressed a wish to change the timetabling of meetings to allow the business to be conducted over one full day. An outline alternative timetable has been prepared and is set out in **Appendix 04/07/13** for consideration by the Committee.

RATIFICATION

10. Resource Development & Finance Subcommittee

A meeting of the Resource Development and Finance Subcommittee is scheduled to take place on Tuesday 9th July 2013.

11. Funding & Contract Subcommittee

A meeting of the Funding and Contract Subcommittee is scheduled to take place on Tuesday 9th July 2013.

12. LPC & Implementation Support Subcommittee

A meeting of the LPC & Implementation Support Subcommittee is scheduled to take place on Tuesday 9th July 2013.

13. Service Development Subcommittee

A meeting of the Service Development Subcommittee is scheduled to take place on Wednesday 9th July 2013.

REPORT

14. Matters of report and any other business

July 2013

Update on the Health and Care Landscape

Government Spending Review

On 26th June George Osbourne announced in his Spending Review that NHS spending will be protected in 2015/16; the NHS budget will be £110bn, a real terms growth of 0.1 per cent in 2015/16.

The existing annual £1billon pledged to social care from the NHS budget will be increased to £3bn in 2015/16. This amount, as well as an extra £0.8bn from other pots of money (such as reablement funds from CCGs and local authority money for disabled housing grants), will be placed into a shared budget between the NHS and local authorities.

Under the new arrangements, funds will be spent on health services as well as social care once they are locally agreed. The money will be routed via CCGs. A proportion of the £3.8bn total will be part of a payment by results model, which will be used to target specific services reducing local admissions to A&E departments. The details of this are yet to be drawn up by DH.

In an interview with *HSJ* Jeremy Hunt said the decision was "a huge moment in the history of the NHS."

He said it would give birth to the NHS's first "accountable care organisations" and introduce the idea of an accountable clinician for every vulnerable older person undergoing care outside hospitals. He added that social care would be required to move to a "seven day" working arrangement if it wanted to access the funds.

Mr Hunt rejected the idea put forward by Labour shadow health secretary Andy Burnham of a government mandated full merger of NHS and social care budgets. He said the coalition's proposals would drive extensive integration across health and social care without "the upheaval and organisational disruption" of a "massive re-organisation of budgets and structures".

Should the coalition win the next election those funds will be increased by a further £2bn in 2015-16 and allocated "according to need" to each of England's local authorities.

Additional announcements in the spending review included:

- Most health staff to be made subject to local performance standards which will link pay progression more closely to performance and not time served;
- There will be a 10% real terms cut to the NHS administration budget. This will include cuts to backroom staff across various organisations, including DH, CCGs, PHE and NHS England;
- There are plans for up to £1bn savings from an overhaul of NHS procurement; and
- Both local government and CCGs will be given their funding allocations further in advance; the details of this will be included in the 2014/15 Mandate, but it is expected that CCGs will be given indicative allocations from NHS England for 2015/16. A letter sent from NHS England to CCGs on the day of the spending review says: "It is NHS England's intention to explore the scope to give CCGs two year allocations for 2014-15 and 2015-16 to support commissioners to deliver the changes required in the NHS to realise the necessary efficiencies."

Reform of payment by results

Following the publication of a discussion paper on reform of the payment by results system by NHS England and healthcare sector regulator Monitor, CCGs will be encouraged to experiment with different ways of paying for care next year. The two organisations said the current system, used mainly for pricing hospital based care, was not always founded on good information and was often cited as a barrier to integrated care.

They went on to say payment by results still paid for activities rather than patient outcomes and its annual cycle of new prices inhibited long-term planning.

Monitor and NHS England are particularly interested in encouraging payment experiments that support health and social care integration. Part of the purpose of encouraging increased experimentation is to allow NHS England and Monitor to gather evidence to guide a redesign of the payment system.

Integrated care

DH has invited health economies to bid to become integration "pioneers" running large-scale experiments in integrated care. Those areas awarded pioneer status will be offered support and advice to help overcome barriers to care integration from a central Integrated Care and Support Exchange team.

There are expected to be 10 pioneers selected in the first wave, and the selection panel would be looking for ambitious, large-scale experiments in integrated care.

In return for support, the statement said pioneers would be expected to "share and promote their experiences and ideas with the rest of the country". It added that further pioneers would be sought in every year until 2015.

Norman Lamb said the local areas that were chosen as pioneers could be offered "flexibilities" around payment mechanisms so that hospitals had a financial incentive to help patients to be supported in community settings. He also said the NHS would be at risk of "collapse" in the long term if a major shift towards integration did not take place: "We must integrate or disintegrate".

NHS England

Under new management… soon

In mid-May NHS England announced that Sir David Nicholson will retire from the NHS in March 2014.

Development of a new NHS strategy

Sir David Nicholson has questioned whether "the straightforward commissioner-provider split" is the best way to organise care for some communities. He has also called for the "cookie cutter" policy of all NHS providers becoming foundations trusts to be abandoned.

At the NHS Confederation conference he announced a major review of NHS strategy which would seek to "liberate" the service to "experiment" with a range of solutions to challenges faced by it.

NHS England will publish a "case for change" in the coming weeks then lead a national discussion with the public on a three-to-five year NHS service strategy. There will also be a "call for evidence" and review of the best "provider landscape". Findings are expected to be published early next year.

Sir David highlighted the uniting of commissioners and providers as one of the main ideas to be explored in the strategy review. "We're very interested in thinking about integration of commissioning and provision and we can work with Monitor and others on how that could work, in particular circumstances and against particular sets of challenges."

Sir David suggested the NHS needed to look closely at US organisations Geisinger and Kaiser Permanente, which serve as insurer and provider for a defined membership.

The following blog from Sir David was published on the NHS England website:

> *High quality care for all, now and for future generations*
>
> This is the first in a series of initiatives to challenge our thinking on the future of health and care and how we organise NHS services so we can provide high quality care to every patient, every time it is needed, sustainably. It is our responsibility to ensure that the NHS is here for our children and their children.
>
> How do we want the NHS to be in the future? This is a question for us as citizens and patients, and for

the communities in which we live. It is a question for everybody who works in health and care. The NHS belongs to us all, and it is for all of us to shape its future.

In July, to mark the 65th anniversary of the founding of the NHS, we will be publishing 'The NHS belongs to us all: a call to action' which will invite everybody to take part in a series of local and national conversations about the long term future of health and care services. We live in a time of financial constraint and rising demand for health services and we need to ask some big questions: what is the future shape of care services? How can we support citizens and patients to take more control of their health and care? How can we transform the patient experience?

We will be asking people how the NHS should develop and expand primary care services and which NHS services should be planned and paid for centrally because they are highly specialised. We want to start a debate about how the internet and digital technology can transform both NHS services and every patient's experience of accessing the right care.

Working with NHS staff we'll be studying the role of commissioning; how our services are organised and paid for locally and what levers exist in this area for improving quality and financial efficiency. We'll be looking at the role of our hospitals in the future and developing ideas for how they can become beacons of excellence, where patients can expect to get the most effective and advanced treatments.

QOF reform being considered

HSJ has reported that NHS England are considering radical proposals to reduce the size of the QOF to free up resources for more 'creative' ways of incentivising GPs to improve patient care. In an interview with Dr David Geddes, Head of Primary Care Commissioning (Operations directorate) he said that the proportion of funding tied to QOF was currently 'quite large' at around 17% and that he was considering working with NICE to reduce it.

Dr Geddes said that NHS England was currently consulting with CCGs, the RCGP and the GPC and that he expected the strategy to include 'more creative' ways of incentivising GPs to work towards 'outcomes rather than processes'.

He also said that NHS England would like to move away from annual reviews of the GP contract, in favour of developing a 'flexible contract' that could be better applied more locally.

Older people's plan being developed

Speaking at the NHS Confederation conference, Jeremy Hunt announced that NHS England is developing a vulnerable older people's plan to help alleviate the stress on A&E services.

He said officials have been told that they have a year to develop and put into place a plan of action to help the "heaviest users of the NHS".

The plan will compromise three elements: Sir Bruce Keogh's review of emergency and urgent care, the joining up of health and social care services, and making sure there are "good alternatives" to A&E.

Academic Health Science Networks announced

In late May NHS England confirmed the designation of 15 new Academic Health Science Networks (AHSNs).

The development of AHSNs was recommended in the 2011 report Innovation, Health and Wealth. The AHSN's core purpose is to enable the NHS and academia to work collaboratively with industry to identify, adopt and spread innovation and best practice. They will develop solutions to healthcare problems and get existing solutions spread more quickly by building strong relationships with their regional scientific and academic communities and industry.

The designated AHSNs are: East Midlands; Eastern; Greater Manchester; North East and North Cumbria; North West Coast; Imperial College Health Partners; Oxford; South London; South West Peninsula; Kent, Surrey and Sussex; UCL Partners; Wessex; West Midlands; West of England; and Yorkshire and Humber.

Public Health England

The new PHE Longer Lives website, that provides comparative data on premature death rates by council area, has been described as "deeply troubling" by the Local Government Association, who warn it could encourage the creation of misleading league tables.

PHE said it has launched the website in order to help councils target action and learn best practice. It shows rates of premature deaths – those before the age of 75 – for cancer, heart and stroke, lung and liver diseases. These four conditions account for 75 per cent of the 153,000 annual premature deaths.

CCG interest in primary care commissioning

Some clinical commissioning groups have told HSJ they are preparing to take a leading role in redesigning primary care, amid what they called a "hiatus" of action from NHS England.

Several CCGs said they were developing plans for the future of primary care in their areas, which they want to be signed off by their local HWB and area team.

A source at a CCG in the south, which is planning to significantly change how acute care is provided in its county, said it was also planning to become the de facto primary care commissioner. It plans to lead the redesign of incentives for GP practices, to encourage practices to federate and provide some services on a networked basis. The work is considered necessary to support its system-wide changes.

In the north, a CCG source told HSJ of a "power struggle" between CCGs and the local area team, as CCGs feel they should be involved in primary care commissioning as they have more credibility with GP practices and are therefore better placed to make the case for change.

Monitor to examine whether GP services operate in the best interest of patients

Monitor is to examine the commissioning and provision of GP services in England to see if there are barriers preventing patients from securing access to the best possible care.

The health sector regulator wants to hear from patients, GPs, commissioners and other providers of primary and secondary care. They are particularly keen to receive evidence on:

- Patients' ability to access GP services, including their ability to switch practices;
- The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations; and
- New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented.

This is not a formal investigation under Monitor's enforcement powers, nor is it a review of the quality of individual GP practices in England. Under its primary duty to protect and promote the interests of patients, Monitor wants to increase its understanding of this part of the health sector at a time when it is operating under increased pressures.

Monitor will publish an update and set out any next steps in the autumn 2013.

Increase in hospitals predicting deficits

Information gathered from board papers by HSJ reveals an increase in the number of trusts that are predicting a deficit this financial year. Eleven hospital trusts are currently predicting deficits at the end of 2013-14, representing a deterioration on the position at the same time last year, when only five trusts were predicting a deficit.

CQC chair admits mistakes

The chair of the CQC has admitted to HSJ that it made a mistake in not initially publishing the names of those implicated in the alleged cover up over Morecambe Bay: "We should have published and been damned."

Mr Prior told HSJ the CQC had received "legal letters" threatening action under the Data Protection Act after individuals named in the report were sent details of the criticisms they would face in the report ahead of its publication.

Mr Prior told HSJ that one of the main reasons for it deciding to publish the names, less than a day after the initial publication, was the Information Commissioner's indication that the law should not prevent it from doing so.

Asked whether, with hindsight, he thought the CQC should have consulted the commissioner before publication, he told HSJ: "When you employ top lawyers you sort of expect it might have occurred to them to do that.

"But the answer isn't to blame the advisers, we took the decision not to put the names in and that was a mistake. Mea Culpa, guilty as charged."

NHS launches IT security review of health data

The Health and Social Care Information Centre is launching a review of whether health and social care data is secure from hackers, amid increasing concerns about cyber security. HSCIC non-executive director Sir Ian Andrews, who also chairs the Serious Organised Crime Agency, will lead the review.

Urgent and Emergency Care services

Professor Sir Bruce Keogh's Urgent and Emergency Care Review was announced in January this year. Its aim is to develop a national framework to build a safe, more efficient system, 24 hours a day, seven days a week.

An evidence base for change and emerging principles that will guide the Review, were recently published and are open for public comment.

The review is one part of a national approach to improving the way NHS services are delivered so that patients get high quality care from an NHS that is efficient now and secure for future generations.

The 'Emerging Principles from the Urgent and Emergency Care Review' document includes the following reference to community pharmacy:

(2) Increase my or my family/carer's awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition.	• Increased patient, family/carer education to self-care and self-manage • 7 day continuity of care from a patient's GP practice • 7 day access to community, mental health and hospital nurse specialists • 111 service fosters communication and co-ordination between different elements of the urgent care community, whilst developing an effective and expanding directory of services in every locality • 111 website and NHS Choices better linked to charity and other support groups and their information • Improve status and use of pharmacists

The 'Evidence base for the urgent and emergency care review' document contains the following content of interest to community pharmacy:

5. Self-care and self-management

Self-care for minor ailments and self-management of long-term conditions play a crucial role in influencing the level of demand for urgent and emergency care. It is thought that about 80 per cent of health problems are treated or managed at home, without resorting to the use of NHS services. Because the number of minor ailments and long-term conditions dealt with through self-care and self-management is very large, minor changes in behaviour have significant potential to affect demand for formal health care, including urgent and emergency services.

Improving access and encouraging the use of support for self-care of minor ailments could help to free capacity in primary care and prevent unnecessary use of urgent and emergency care services.

The treatment of minor ailments within primary care accounts for about 20 per cent of total available GP workload and is estimated to cost the NHS about £2bn.

There has been rapid growth in the use of online health tools over the last ten years and there is an increasingly wide variety of options available to patients. Recent estimates have found, for instance, that there are over 40,000 medical applications available for download on tablets and smartphones and so far the market is unregulated for both doctors and patients. A study into NHS Direct's online symptom checker found that most users were young (71 per cent under 45 years old) and most were female (67 per cent) which indicates wide use for this cohort of patients. Although, approximately 44 per cent of users sought consultation with a health professional after using the NHS Direct website symptom checker and most of those who did not, fell into the younger age group categories.

Evidence suggests that if more members of the public are supported to undertake self-care and self-management, fewer patients will access unscheduled care within the same episode of care. There is, however, some inconsistency in the level to which health professionals are thought to recommend and support self-care and self-management and it is suggested that many people do not have the necessary confidence, or health literacy, to treat or manage their condition themselves.

The extent to which a patient is actively involved in their own care is strongly linked to health outcomes. Research shows that, by supporting self-care, the NHS can improve health outcomes and increase patient satisfaction. However, self-care requires the ability to:

- assess one's own health care needs;
- acquire an understanding of the options available; and
- select and access the most appropriate option.

Previous research has demonstrated that some people with minor ailments abandon self-care earlier than they need to, and depend too highly on support from formal healthcare services because they do not have the confidence or knowledge necessary. It is possible for patients to be educated to manage their own condition, reducing the likelihood of future exacerbations and hospital admission, through contact with the NHS. Although there is limited evidence to demonstrate that this is cost-effective across the health economy, self-management programmes have been shown to improve patient experience, adherence to treatment and medication and reduce emergency admissions to hospital.

Approximately 80 to 90 per cent of patients with long-term conditions, as well as their carers, can be supported to actively manage their own health. Some people with long-term conditions consistently say that they want more access to information and support to help them understand and manage their condition. This suggests that there is significant scope for the NHS to improve health literacy and help people manage and prevent their own illness and injury through improved self-care and self-management. However, analyses of self-management courses have found that their impact is also somewhat limited because they are dominated by the most affluent and educated patient groups with long-term conditions, who already consider themselves to be effective self-managers. The vast majority of patients with long-term conditions are not aware of self-care and self-management support options and there is sometimes a lack of awareness surrounding how to access the necessary resources.

Key message

Self-care for minor ailments and self-management of long-term conditions are effective at improving quality of life and reducing dependency on urgent and emergency care services; however there is a lack of awareness surrounding how to access self help and the demographic groups most likely to benefit are least likely to be aware.

Evidence suggests that care planning can improve a patient's ability to self-manage and reduce emergency admissions to hospital for patients with long-term conditions that are prone to rapid deterioration. A care plan enables identification of the issues related to a patient's condition and helps them develop ways to self-care; improving their quality of life and reducing the likelihood of their condition deteriorating. However patient survey data found that only about 12 per cent of patients with long-term conditions report that they had been told they had a care plan. A recent qualitative study of patients with long-term conditions found that patients generally received some elements of care planning but a structured, comprehensive process was not evident. In the ten years from 2001 to 2011 the number of emergency admissions to hospital for conditions that could be successfully managed in primary care in England increased by an estimated 40 per cent. They now account for approximately one in every six emergency admissions to hospital in England and cost around £1.42bn a year.

Key message

Variable management of long-term conditions in primary care may have contributed to a rise in the number of emergency admissions to hospital.

It is estimated that approximately 18 per cent (or 51 million) GP consultations per year concern minor ailments alone, which could largely have been dealt with through self-care with support from community pharmacy services. These services can also be an important source of advice and support for patients managing long-term conditions. With approximately 10,500 community pharmacies across England, the widespread availability of services means they are usually easy to access, with 99 per cent of people in England able to get to their local pharmacy within 20 minutes by car and 96 per cent by walking or using public transport.

Many community pharmacies have long opening hours, which means they can provide a source of medical advice or treatment for some patients when their GP surgery is closed, potentially reducing the need for them to use out-of-hours GP services.

The traditional role of community pharmacies is to support patients in the safe use of over-the-counter and prescription medicines. More recently this role has expanded significantly to include: providing advice and treatment for common minor ailments, promoting healthier lifestyles, and supporting people with long-term health conditions. Increasingly, pharmacies are being encouraged to provide enhanced services designed to reduce the need for GP and urgent care services. Eighty-five per cent of pharmacies have a consultation room, which enables pharmacists to provide services traditionally delivered by GPs. These include:

- Minor Ailment Schemes, where pharmacists provide consultations for patients with common minor ailments; and
- The New Medicine Service, where a pharmacist supports patients with selected chronic conditions using new medicines.

Small-scale evaluations of minor ailment schemes have found that treatment of common conditions in a pharmacy setting can be cost effective and can release healthcare resources, particularly GP appointments. However, studies have found that a lack of awareness and public trust in the range of services provided by community pharmacists poses a barrier to increased uptake of the services. A 2010 survey found that only 23 per cent of pharmacy users considered pharmacies to be the best place from which to seek general health advice, with patients preferring to consult their GP. Research suggests that pharmacists still spend the majority of their time involved in activities associated with dispensing medicine and are less confident when it comes to providing other areas of healthcare.

Key message

Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions; however there is little public awareness of the range of services provided by pharmacists.

In early July it was reported that DH is reviewing the entire "concept" of the NHS 111 service, as part of Sir Bruce Keogh's review. HSJ reported that Jeremy Hunt has questioned whether the urgent care service currently made "it as easy as it needs to be" for patients to speak to clinicians.

Mr Hunt said Sir Bruce's review would play a very important role in convincing the public to back radical changes to hospital emergency departments.

"If you want to make big service change then you have to give the public confidence that if they need to get in front of a doctor in an emergency, out of hours, they are going to be able to carrying on doing so," he said. "And I don't think the structures, the way we have approached reconfiguration, [have] succeeded in doing that – and we have to find a better way.

"When we get that [the Keogh review] completed, we'll be in a much better position to the carry the public with us in changes I've always accepted it would be important to make."

Amendment of the PSNC Constitution

Deputies

RAP was asked to look at the rules for attendance of deputies at PSNC meetings, and this was discussed at the meeting held on June 21st.

PSNC has for many years allowed deputies to attend full meetings of the Committee. This is an unusual provision which dates from the time when multiple pharmacy representatives had very few seats on the Committee, and they were anxious to ensure that they were able to be represented if the appointed member was ill or otherwise unable to attend. Most organisations, including pharmacy organisations, do not allow deputies. Deputies have never been able to attend PSNC's subcommittee meetings.

RAP explored options for permitting deputies to attend subcommittee meetings. There is a concern that this could adversely affect the progress of subcommittee work, if consistency of members is lost, and that regular use of deputies could affect the cohesion of the Committee.

RAP discussed a framework for permitting deputies to attend PSNC meetings, including subcommittees. This is summarised as follows:

- Eight nominated deputies will be appointed, as follows: 3 for CCA, 1 for AIMp/non-CCA multiples, 3 for regional reps, 1 for NPA.
- Deputies must be pharmacists employed by the relevant sector or a pharmacy owner.
- Where a PSNC member is unable to attend a meeting, one of the nominated deputies will attend on his/her behalf. S/he will deputise for the whole meeting – the subcommittee and the plenary meeting.
- The current provisions for repeated absences will remain unchanged, so a member must attend at least one meeting in every three.

RAP has not discussed how the deputies will be selected. This is not an issue for members appointed by the CCA or the NPA, but will need to be considered for elected members. A decision will also need to be made how the deputies should be treated in the Constitution: whether they become additional members of the Committee fully subject to the code of conduct and routinely receiving all papers, or not.

As this is a substantial change and will require a 2/3 majority for amendment of the current rule, the Committee is asked to consider the proposal and vote on the principles before the changes are drafted.

Eligibility for regional representative election

RAP was asked to review the Constitution, concerning the eligibility of independent pharmacy contractors for election as regional representatives.

At present (post May 2013) a contractor seeking election as a regional rep must own nine or fewer pharmacies and not be a member of the Association of Independent Multiple pharmacies (AIMp). However, there is no explicit ineligibility for owners of a multiple which also has a single pharmacy owned through a separate company, from seeking election as a regional representative.

The matter RAP was asked to consider was whether a group or association of contractors, which are effectively part of the same business, should be entitled to participate in the multiples election, or the regional representative's election.

RAP recommendation

RAP preferred the approach of defining a Regional Representative as someone who does not have substantial ownership of more than nine pharmacies – i.e. to prevent someone standing as a Regional Rep who owned one pharmacy in his own name or through a company, but who also effectively owned more than nine pharmacies in total.

The proposed amendment to the Rules is to add a new sub-paragraph to 11.4 (candidate eligibility)

11.4.3 A person shall not be eligible for election as regional representative if he has substantial ownership (either personally, in partnership or through shares owned by members of his immediate family, i.e. parents, spouse or children) in more than nine pharmacies.

The proposed amendment to the Constitution is to add a new sub-paragraph to 9.2 (ineligibility of elected Independent Chemist)

9.2 An elected Independent Chemist shall become ineligible if:

9.2.3 he has substantial ownership (either personally, in partnership or through shares owned by members of his immediate family, i.e. parents, spouse or children) in more than nine pharmacies.

PSNC meetings timetable

In the last two years the Committee has changed its way of working to encourage greater use of group discussions or training sessions and members' attendance at all subcommittees, as well as developing opportunities for engagement with LPCs.

The current timetable is designed to allow Committee members other than members of RDF to travel on the Tuesday, and to finish by lunchtime on Wednesday. It allows time for subcommittee minutes to be prepared and presented at the Plenary meeting, and for Committee members to reflect on subcommittee and group discussions informally over dinner. Total meeting time (excluding LPC briefings) is 12 hours including refreshment breaks.

The alternative timetable would require most members to travel on the Tuesday late afternoon, to be able to attend FunCon at 9am on Wednesday, and to travel home on the Wednesday evening. Informal discussion would take place before most of the subcommittees. Total meeting time available (excluding LPC briefings) is 10 hours including refreshment breaks.

The Committee is asked to decide which timetable it wants to adopt for future meetings.

1. Current timetable for PSNC Meetings (indicative)

Tuesday	9.30am	RDF
	11.00am	FunCon (including group discussion)
	2.00pm	SDS (including group discussion)
	4.00pm	LIS
Wednesday	9.00am	Training or group discussion
	10.30am	Plenary
	1.00pm	Close of meeting
	2.00pm	LPC briefing

2. Possible alternative timetable

Tuesday	3.00pm	RDF
	6.00pm	LPC briefing
	8.00pm	Dinner
Wednesday	9.00am	Plenary meeting
	10.30am	FunCon
	1.15pm	SDS
	3.15pm	LIS
	5.00pm	Close

Note: members of the Committee would be expected to attend but not participate in meetings of subcommittees of which they were not a member. At the conclusion of subcommittee meetings the chair would seek approval from the Committee of recommendations made by the subcommittee, and any confidentiality issues would be considered.