All PSNC members can attend this meeting and may speak with the permission of the Chairman.

PSNC Health Policy and Regulations Subcommittee Agenda

Meeting to be held on Tuesday 11th October 2016

Harte and Garter Hotel & Spa, Windsor, in the Cavesson room, 4 -5.15pm

Members: Ian Cubbin (Chair), David Evans, Margaret MacRury, Prakash Patel, Janice Perkins.

Apologies for absence

No apologies for absence have been received at the time of setting the agenda.

Minutes of the previous meeting and matters arising

The minutes of the last meeting held on 12 January 2016 were shared with the subcommittee and are available on the PSNC website.

Agenda and Subcommittee Work

Agenda items are set out under the strategic aims of the year, first matters for decision, second, matters of report.

All ongoing matters are set out in **Appendix HPR 02/10/16.**

1	Proactively seek changes to the regulatory framework that support contractors and will robustly respond to proposals from the Department of Health and NHS England

On 24 May 2016, PSNC submitted its response to the Department of Health / NHS England letter dated 17 December 2015, when the public consultation officially ended.

A revised proposal has been received from the Department of Health in a letter dated 9 September 2016, which will be discussed in plenary session. There are two aspects of the proposal for discussion by the subcommittee, a revised Pharmacy and Access Scheme (Phas) and the proposed market entry changes.

MATTERS FOR DECISION

a) Planned protection for patient access – Phas

The Department of Health (DH) intends to launch a Pharmacy Access Scheme (Phas). The scheme is intended to be a national scheme to protect patient access to pharmaceutical services and will see extra payments made to eligible pharmacies.

A revised scheme was set out in the DH's letter of 9 September which provided amongst other details that:

i. Before we make any of the calculations, we will exclude the largest pharmacies by volume (the top 25%);
ii. Two stages of eligibility:
Firstly, pharmacies that are a mile or more from another pharmacy will be automatically eligible;
Secondly, we look at a composite index, accounting for population travel times and needs (now removed);
iii. The second stage is an extra measure to ensure that no populations with high needs will slip through the net in terms of access;
iv. We think it is right that all pharmacies make efficiencies, and so Phas pharmacies will receive a top-up payment to take them back up to their 2015/16 levels of remuneration, minus a 3% efficiency saving (1% during 2016/17);
v. We think this strikes the balance between giving contractors certainty and the need to review eligibility to reflect any market changes.
vi. As before, we propose that eligibility to the scheme will remain fixed for the period of the settlement (until March 2018).

On 20 September, the day before a meeting with DH to clarify aspects of the scheme, further revisions were made to the scheme. Significantly, the composite index was dropped from the eligibility criteria.

Attached are a number of papers provided by DH as part of discussions about Phas **(Appendix HPR 03/10/16)**, in particular, the DH presentation of the current Phas proposal and a note of the key clarifications from the meeting on 21 September, which include:

i. LPS pharmacies have been included in the data, but excluded from cost and payment calculations;
ii. LPS pharmacies currently not part of the CPCF - *it has been agreed this issue needs to be considered furthered*; (Former ESPS Local pharmaceutical services pharmacies, which are already facing an uncertain future, are not automatically included in Phas)
iii. Pharmacy location uses the Royal Mail coordinates / data with a margin of error of 8-12m (not just the postcodes);
iv. Distance has always been calculated using road walking times (not as the crow flies);
v. Eligibility is determined at the start of the scheme and no new entrants are included and Phas payments to one pharmacy are unaffected by the closure of any other pharmacy;
vi. Pharmacies that move premises at the start of the scheme – *it has been agreed this issue needs to be considered further*;
vii. The composite index is based on **isolation** - travel time to the pharmacy and additional travel time that people will have to travel if that pharmacy closes (the latter is squared in the formula to give it additional weight) – **needs** - criteria are: index of Multiple Deprivation, proportion of population >75 years who are >85 years, proportion of population >70 years claiming disability living allowance, standardised mortality ratios, generalised fertility rate, age-sex standardised proportion non-white, age-sex standardised proportion tenure social, and age-sex standardised long-term limiting illness (based on the same formula used to determine CCG allocations of drug costs) - and **population** to pharmacy distances assessed from the nominal centre of output areas to the pharmacy;
viii. The 1-mile pharmacy to pharmacy distance was chosen because this is the shortest distance that includes all but 2 of the 700 pharmacies originally selected using the composite index; with the least number of additional pharmacies;
ix. The composite model appears to be heavily weighted on isolation. The needs assessment alone is inversely proportional to isolation – the neediest populations are generally urban;
x. Attainment and payment of the quality payment is assumed before the Phas top-up is calculated; and,
xi. The policy change between 9 and 20 September - DH explained that this followed more analysis of the data.

Additional documents and data are provided about the distribution of pharmacies eligible for Phas and the composite index. Also included is a note of the committee's response to DH, dated 10 March 2016. Additional observations are:

i. Pharmacy eligibility for Phas is determined by pharmacy to pharmacy distance, but the choice of distance is determined by the composite index and contractors will support twice as many pharmacies as DH wants to protect under its composite index.
ii. PSNC is identified as responsible for the distance based rule, which is likely to be translated as responsibility for the scheme, although PSNC actually sought simplicity and a small scheme similar to the former essential small pharmacy scheme (ESPS).
iii. DH is likely to claim to protect the neediest populations through reference to the composite index, yet may avoid scrutiny of the index.
iv. PSNC has expressed considerable misgivings about the composite index, given that distance measured by population output areas to pharmacy postcodes is imprecise and takes no account of geographical features; the population factor takes no account of practical, patient-centred, real world access; and, the needs factor is too complex and if it can identify only 3 pharmacies in London, is unlikely to have sufficient weighting in the index to be meaningful.
v. Some smaller pharmacies, hardest hit by the proposed funding cuts, will be supporting some larger pharmacies, because Phas includes pharmacies up to the 75th percentile in terms of item volume.
vi. The appeal mechanism appears to be too limited and is confused.

But

vii. Phas will give financial support to almost 1,400 pharmacies until March 2018.

In conclusion, it is suggested that Phas meets, in part, the need to protect patient access to some pharmacies, but it is not a scheme that meets patient needs and access across the country.

For the Committee:
The subcommittee is asked to consider the current Phas proposal and identify relevant issues for the committee.

b) Market Entry

The market entry changes have been agreed in principle, and will provide quadruple protection against other pharmacies opening up in response to this form of closure or consolidation, as follows:

1. HWB must comment on an application and indicate whether it would or would not create a gap;
2. NHS England may only grant an application if no gap is created;
3. HWB must publish a supplementary statement (which is public) that confirms no gap was created; and,
4. A subsequent unforeseen benefits application based on such a closure or consolidation must fail.

Extending the PNA reviews from 3 to 5 years was requested, but considered by DH to be unachievable, because there was insufficient time to obtain agreement from Local Authorities.

For the Committee:
The subcommittee is asked to confirm its agreement to the proposed market entry changes.

MATTERS OF REPORT

c) Planned numbers - Planned reduction

The Department of Health states that its intention is to change the funding structure and that this may lead to a reduction in pharmacy numbers. On this basis, there is unlikely to be any legal claim for compensation. If the Department's intention is to reduce the number of pharmacies because there are too many, it may be possible to argue for compensation.

Next steps:
There has been no change since the last meeting, and as soon as a determination is announced by the Department of Health, PSNC can consider its position.

d) Hub and spoke / centralised dispensing

On 23 May 2016, PSNC submitted and published its response to the consultation on 'hub and spoke' dispensing which is at http://psnc.org.uk/our-news/psnc-responds-to-hub-and-spoke-consultation/ .
On 7 June 2016, the Government postponed plans on hub and spoke dispensing.
On 6 September 2016, the DH held a meeting of relevant stakeholders to discuss hub and spoke dispensing and a note of the meeting is awaited from DH. Key points from the meeting include:

i. DH's current intention is to provide a 'level playing field in terms of the law'.
ii. DH no longer considers that any legislative changes are required for hospital pharmacy (although the hospital hub and spoke models permitted under current legislation were disputed with DH during the meeting).
iii. DH's assertion that there had been a 'mixed response' to the consultation was disputed. The answers to the first two questions were:
Do you want hub and spoke dispensing? Y 28, N 28 No response 44
Do you agree no restriction on models? Y 17, N 44 and no response 40
It was suggested that there was little support for the proposals.
iv. It was disputed that any of the consultation responses could be relied upon given that the narrative of the consultation did not match the draft legislation and, therefore, respondents were not aware of exactly what was being proposed (i.e. they were not consulted).
v. The main issues raised in the PSNC response to the consultation were not addressed at the meeting.
vi. DH agreed to provide a 'summary of the meeting', would 'not commit to a further consultation' and indicated they would 'get back in writing on the next stage'.

The Chair acknowledged that there was limited appetite for continued discussion of the issues if the fundamental problems were not addressed.
Next steps:
To await the summary of the meeting and the next stage.

Consideration will be given to options for challenging any decision the Department of Health may make on hub and spoke dispensing.

2 PSNC will address operational issues affecting pharmacy practice, working to secure the best outcomes for contractors

MATTERS FOR DECISION
None.

MATTERS OF REPORT

a) Primary Care Support England (PCSE)

PCSE (formerly Primary Care Support Service – PCSS) provides administrative and payment services to community pharmacies amongst others. On 1 September 2015, Capita assumed responsibility for the delivery of most of NHS England's primary care support services.

During the summer, the Director of Operations and Support wrote to NHS England about poor delivery of controlled stationery, poor market entry management and poor customer service and received a response from Karen Wheeler. Since then, a review of PCSE service delivery has been announced. There have also been

changes in the senior management responsible for this work at PCSE/Capita and NHS England staff have been drafted in to help sort out the operational issues.

NHS England has at last understood the scale of the problem, but for the time being the issues remain for pharmacy and the other professions.

PSNC is also starting to see problems with pharmacy payments and is escalating issues to PCSE/Capita.

Next steps:
The Director of Operations and Support and/or the Regulations officer to continue to attend stakeholder meetings with PCSE/Capita and submit evidence to the service review.

b) Discretionary payment claims - Switching

Currently NHS England is not making discretionary payments and a number of contractors are seeking such payments, particularly in relation to issues associated with the submission and payment of electronic prescriptions. These issues were under discussion in 2015 and before and discussions with DH are ongoing.

Next steps:
To continue to progress and report to the next meeting of the subcommittee.

Any other business.

Appendix HPR 02/10/16

Report on progress on matters previously discussed by the subcommittee (October 2016 agenda)

Matters worked on between July 2015 to present (starting with most recent open workstream items and descending to closed workstream items)			
Item/description of workstream	**Most recent action/s**	**Current status**	**Date of last subcommittee meeting**
Direction of Prescriptions	To continue to support LPCs and contractors, and collate evidence, sharing with Pharmacy Voice and the NPA where appropriate.	Open	7/16
Visitor and Migrant cost recovery	Will Goh is now attending these meetings	Open	7/16
Discretionary payments	Specific case. Agenda item	Open	10/16
Planned protection for patient access – Phas	Agenda item.	Open	10/16
Market entry	Reported and noted. Agenda item.	Open	10/16
Hub & spoke	Department of Health consultation on Amendments to the Human Medicines Regulations 2012: 'Hub and spoke' dispensing, prices of medicines on dispensing labels, labelling requirements and pharmacists' exemption. It is not clear whether DH will progress this, or not. Agenda item.	Open	10/16
Accessible Information Standard	In April 2016, PSNC and Pharmacy Voice jointly produced an update for those working in community pharmacy: The Accessible Information Standard: Update on implementation in community pharmacy. The September review by NHS England has been postponed to Jan-March 2017	Open	07/16
Rebalancing	Director of Operations & Support has followed up previous requests to DH to be part of the working group on supervision, but without success.	Open	07/16
Discretionary payments and "switching" etc.	Was "on hold" pending community funding consultation outcome. Department of Health meeting on 28 September. Legal advice will be sought. Agenda item.	Open	10/16

FMD	Delegated Acts issued. Department of Health currently holding meetings with stakeholders regarding implementation. Following a PSNC response to the proposed UK MVO, it is likely that PSNC, CPW, CPS and CPNI, with other community pharmacy representatives will be directly involved with the formation of the UK MVO.	Open	07/16
Co-Commissioning	Informal discussions so far. Legislation may need to be amended, and the co-commissioning will be "complementary and supplementary to the core contract". The Director of Regulation and Support provided comments on a draft of: 'Managing conflicts of interest: revised statutory guidance for CCGs'. The revised guidance was published in late June 2016.	Open	7/16
PCS England and Capita	On 1st September 2015, Capita took over responsibility for primary care support services. PSNC has written to NHS England to raise concerns. Agenda item.	Open	10/16
Contract monitoring/CPAF Including reports of inappropriate action	The CPAF screening questionnaire continued in 2016/17 which ran from Monday 6th June 2016 for four weeks. Ongoing – full CPAF and next year, visits. Issues with compliance or way some questions have been asked; being considered with PSNC	Open	7/16
Managed Repeats	In August 2016, advice was issued in conjunction with Pharmacy Voice	Closed	7/16