Private and Confidential for LPC members only

Representing and Supporting NHS Community Pharmacy in the Humber

A proposal for the future of Humber LPC

To be considered by LPC members

7/12/2022

Contents

1. Forward by LPC Chair to LPC Members
2. Executive Summary
3. Background
    a. Existing structures
    b. SWOT analysis
    c. LPCs responding to the RSG proposals
    d. LPCs responding to the changing environment in the NHS
    e. Purpose of the paper
4. Proposal recommended for the future of the LPCs
    a. Overview
    b. Case for change and benefits
    c. Representation and proportionality
    d. Finance and justification
5. Contractor engagement
6. Decision making
7. Critical path
8. Next steps
9. Appendix 1 - CPH LPC data
10. Appendix 2 – ICS Structural data
11. Appendix 3 – CCA checklist
12. Appendix 4 – CCA options summary's
13. Appendix 5 – Services comparison
14. Appendix 6 – LPC functions detail by option
15. Appendix 7 – Constitutional Extracts

Forward by Paul Robinson Chair of Community Pharmacy Humber

As chair of Community Pharmacy Humber for many years I am proud of the work it has done on behalf of its contractors within our distinct and NHS aligned geographical footprint.

We have adapted to the many changes in the NHS over the years and since the creation of the concept of STP's, which have ultimately developed into Integrated Care Boards, we have modified our approach to representation to work in close partnership with our neighbouring LPC Community Pharmacy North Yorkshire (CPNY).

Our ICB has two distinctive geographical partnerships within it built around the geography of the Acute Trusts and Local Authority boundaries and there are distinct differences between the two, particularly when it comes to the provision of local pharmacy services.

We have worked collaboratively with CPNY to ensure effective representation for Community Pharmacy within the various developing structures which operate at ICB total footprint and at geographical partnership levels. This level of representation has required sharing of responsibility and resource between the two LPC's and has resulted in some significant achievements in securing ICB level funding for service developments such as the Walk in Consultation service, which operates across the ICB, and other more local initiatives such as the COPD pilot in Humber which meets a local need at PCN level.

The joint meeting of Chairs and CEOs of the two LPC's considered all options and agreed our preferred option of the three that we felt were worthy of consideration by the individual LPC's as detailed in this paper.

The LPC needs to consider the pros and cons of all the options at our meeting on the 7th of December 2022 and agree the way forward for Community Pharmacy Humber to ensure the best representation for our contractors going forward into an ICB commissioned community pharmacy service.

Executive Summary

The Wright report and subsequent RSG vote have instigated many changes to how PSNC and LPCs adapt and align themselves for both the changing local NHS structures and PSNCs national aspirations.

A workplan has been adapted to allow LPCs to assess their best fit with the local NHS structures and ability to meet PSNCs funding expectations.

Alignment with NHS structure, namely LPCs aligning with their ICS, is being considered. Which may require significant structural changes.

The chairs and CEOs of both LPCs within Humber and North Yorkshires ICS footprint have jointly considered how our LPCs meet the various criteria supplied by the TAPR workstream, and honour the RSG contractor vote, to adapt to the changing times.

This paper details the various available options discussed, short listed and preferred by the chairs and CEOs.

This paper should provide the supporting information to allow the LPC committee to come to its decision on the preferred option from the following:

- Merger with CPNY
- Federate with CPNY
- Collaborate with CPNY in a more defined manner, keeping our current geography and identity.

This choice will then trigger a confirmatory contractor vote via SGM to acknowledge it, adopt the new constitution, and term extension for the current committee while changes are implemented.

Background

A. Existing structures

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 long-term plan and they include the development of Integrated Care Systems (ICSs). The impact of these changes on local commissioning and the local providers and representatives involved in it cannot be underestimated. Community pharmacy contractors need strong local leadership from their LPCs more than ever, making sure that as local commissioning changes, pharmacy is part of the new pathways from the start.

LPCs have an important role going forward, and it is essential that they reform to respond to these regional changes to ensure effective engagement with ICSs and more efficient and consistent delivery of support to contractors. Fewer but better resourced LPCs operating at a regional level are more likely to deliver impact for contractors in how the NHS is organising itself.

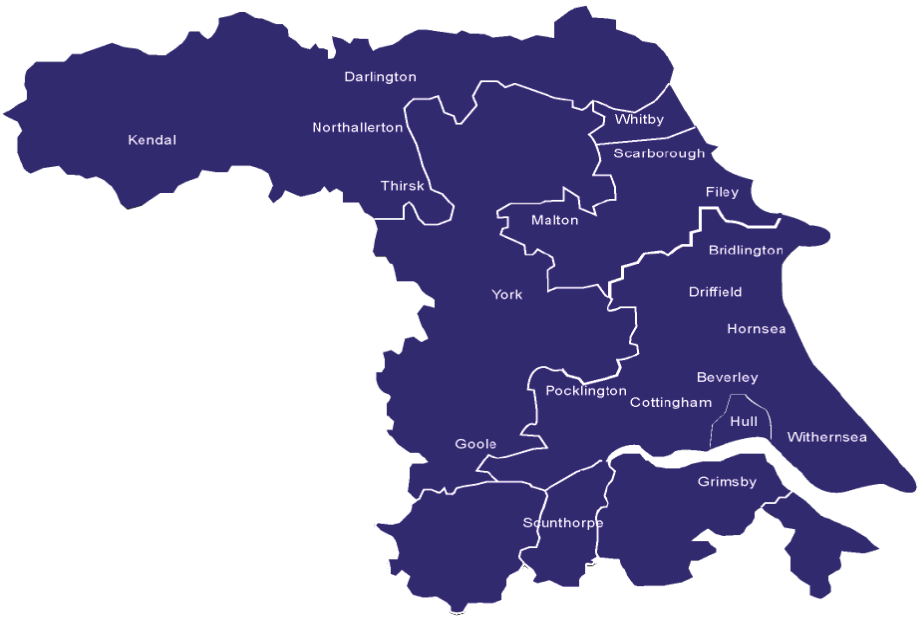
Alongside these structural changes, the health and care system is trying to find new ways to manage the immense financial and demand pressures that it faces. The unsustainable pressures on GP services mean there will be opportunities for other healthcare providers to do more (recognising the current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

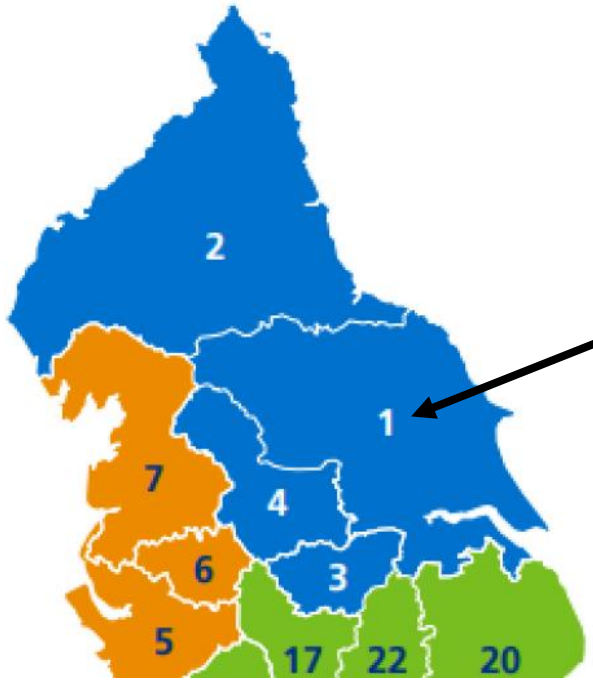
This need for renewed work with, often newly appointed, local commissioners comes at a time when contractors are being hit hard by funding cuts and are coming to terms with changes to the Community Pharmacy Contractual Framework (CPCF).

Unsurprisingly, LPCs report that their contractors are increasingly looking to the LPC to provide them with more support, implementing contractual changes such as the Pharmacy Quality Scheme and supporting local and national service provision, such as the NHS CPCS and Hypertension Case-Finding Advanced services.

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 2022/23 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. To aid in this reflection the next pages will describe the local NHS picture and the LPCs place in it. It will also look at what a local best fit would be for our contractors, and this LPC, bearing in mind the NHS changes and the work done from the Wright review, and the subsequent RSG vote, for the ICS geography below.





NHS Humber and North Yorkshire Integrated Care Board (ICB) is responsible for planning and arranging the provision of NHS services to meet the diverse health needs of a population of over 1.7 million people. Our area reaches over 1,500 square miles and includes the cities of Hull and York and the large rural areas across East Yorkshire, North Yorkshire, and Northern Lincolnshire.

The ICB is part of the Humber and North Yorkshire Health and Care Partnership, one of 42 Integrated Care Systems (ICS) across England to meet health and care needs, coordinate services and plan in a way that improves population health and reduces inequality between groups. The Health and Care Partnership comprises of NHS organisations, local councils, health and care providers, and voluntary, community and social enterprise (VCSE)

H&NY Key facts

General Practice
- 181 Practices
- 43 PCNs following changes in Hull and North East Licences
- More than 800,000 appointments in 2021/22
- More than 5,000 FTEs across the workforce
- More than 200 additional roles (ARRS) being recruited to this year

Pharmacy
- 330 Community Pharmacies

Optometry
- 165 Community Optometrists

Dentistry
- 150 GDS contractors (GDS = General Dental Services contract – no end date)
- 19 PDS contractors (PDS = Personal Dental Services contract - usually time limited)

Appendix 2 contains several examples of the ICS internal structure showing a clear functional split between Humber and North York's that is built into how the ICS operates.

For geographical comparison with neighbouring ICS's

B. SWOT analysis

A central recommendation of **RSG** was that LPC (and PSNC Regions) should ensure their geography more closely aligns with ICSs. As LPCs consider how they become co-terminous with (at least) one ICS this will involve close engagement with neighbouring LPCs.

- Convene a working group with neighbouring LPCs to:
  - agree a proposal for new LPC boundaries (where necessary)
  - explore systems and processes which could drive efficiencies

The 3 LPC CEOs in this PSNC region met in October to discuss ICS borders. Talks clarified the borders and identified an issue around Craven that WYorks and NYorks LPCs need to address themselves. Humber and NYorks only have any mapping with Humber and North Yorkshire ICS. Therefore any further in-depth discussions need only be between CPH and CPNY.

Next steps would be the LPCs considering any possible ways of working against the key strategic TAPR questions.

Here is a checklist for the items that need to be considered:

- **Does our current structure match that of the NHS?** The structures of the NHS have changed significantly. The LPC will work closely with neighbouring LPCs to work out the best footprint for the benefit of local contractors. If you are not currently co-terminus with an ICS, you should be considering what the options available to you are and discussing this at both a regional level and within the LPC. Each option should be discussed and if possible, an agreement across LPCs reached about what the desired future geography for each LPC should be. The momentum of change is towards LPCs more closely matching their boundaries with their ICS, by having a representation and governance structure (LPC members) at a system level, allowing for investment in executive resource to undertake system and place-based work.

- **Are we the right size?** Recent reviews have concluded that LPCs over 200 contractors are able to deliver the best value. If your LPC currently has fewer than 200 contractors, you could explore opportunities across your region on how to create an LPC of greater size (or indeed smaller size if this rebalances contractors into boundaries co-terminus with ICSs). PSNC will be supporting those who want to change but understand that contractors in an ICS area smaller than this may come to a different conclusion. LPCs are independent and sovereign entities.

- **Are we being effective and efficient with our finances.** The RSG was clear that PSNC would require increased funding to deliver as effective as possible national negotiations and CPCF. Alongside this there was an ambition that overall CP representation funding would not increase. LPCs should be exploring how they will fund the increased PSNC Levy whilst ensuring their LPC is efficient and effective.

- **What are we called?** There was lots of support for a rebranding of LPCs into 'Community Pharmacy <local>, where 'local' is a description of your area. CPH already meets this metric but may need to change depending on the outcome.

- **How big is our LPC committee?** LPC committees are of varying sizes. The RSG recommendation was that they should be between 10-12 members. CPH has 13 members in principle.

C. LPCs responding to the RSG proposals

Following the recent contractor RSG vote, it has been established that aligning LPC boundaries to current ICS structures is an important factor to maximise representation following Community Pharmacy contract delegation in April 2023. Essentially, LPCs will need to concentrate on this big structural change within the NHS over the coming years, making sure the committee is geared up and aligned to work with the new ICSs which will require careful planning.

Highest priority RSG proposals that LPCs will need to respond to:

LPCs are to drive efficiencies by reviewing boundaries and committee sizes, considering NHS changes with the aim of:

- **Being able to meet increased contributions to PSNC, without having to increase contractor levies.**
- **Having a representation and governance structure (LPC members) at a system level,** allowing for investment in executive resource to undertake system and place-based work.
- **LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size** (in terms of numbers of contractors represented) in line with the Wright Review recommendation that LPCs with a minimum of 200 contractors provide better value. [Any changes would be subject to the views of contractors via a local vote at a special meeting of contractors]
- **To adopt a new model constitution** that focuses levy-funded activities on a core scope of activities and is in line with the new cross-sector governance framework.

D. <u>LPCs responding to the changing environment in the NHS</u>

LPCs will need to concentrate on structural change within the NHS over the coming years, which will require careful planning:

- *Horizon scanning and monitoring:* keeping up to date with organisational and structural changes within ICSs and other relevant organisations, so the LPC is ready to act and does not miss opportunities to engage.

- *ICS relationships:* building relationships with ICS leaders and ensuring they understand what community pharmacy can offer; gaining places on ICS implementation teams/working groups, or potentially on ICS Boards (but recognising that sometimes, more effective influence may be achieved at a lower level).

- *Working with other stakeholders:* maintaining and, where necessary, building relationships with other commissioning organisations, - local authorities, secondary care, the Regional NHS England team, and any prime-providers for local services.

- *Working with GPs:* building an appreciation of community pharmacy's services offering with GPs to support closer working and commissioning opportunities, particularly at ICS, PCN and LMC level.

- *Patient groups:* maintaining and, where necessary, building relationships with organisations representing patients, for example, Patient Participation Groups and Healthwatch.

- *Working closely with NHS England's Local Professional Network (LPN).*

- *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 CPCF requirements and on local matters; 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.

- *Commissioning work:* continuing to try to get local services commissioned and to try to prevent any decommissioning of pharmacy services along with protecting existing 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.

- *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.

E. Purpose of the paper

To provide the LPC committee with all the relevant information to assess the preferred and other potential options for the future of community pharmacy Humber, considering the changes in the NHS nationally and locally, as well as the recommendations from the wright review and its proposed changes to representation provided by the RSG and voted on by contractors.

4. Proposal recommended for the future of the LPCs

A. Overview

The Wright Review found duplication of efforts on some tasks across LPCs, as well as varying value for contractors from their LPCs, and it supported rationalisation of the LPC network to free resources for more local and national activity, in doing so considering NHS geographical footprints, value for money and numbers of contractors represented by each LPC. This was confirmed by contractors through the RSG contractor vote. The following points clarify what needs to be considered with regards to any proposals.

B. Case for change and benefits

The main objective of changes that contractors wish to see (which are in line with the Wright Review) is to ensure that all LPCs have the resources and expertise to represent, advise and support contractors locally, and to release levy monies to fund critical national work to drive greater overall value from the levy. A significant body of evidence in the Wright Review pointed to lower levies and improved efficiencies once the number of contractors represented by an LPC passes 200. Levies from merged LPCs yield greater income from a greater number of contractors. Savings could therefore come from reviewing LPC office operations, and possible reductions in meetings, meeting format and times.

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 single dedicated employed Chief Officer with administrative support. Other functions now include:

- Service implementation
- Support for 'business as usual'
- Communications
- Data analysis and project outcome support

With all of these supporting the Chief Officer to maintain a strategic development focus for the LPC.

LPCs must ensure future needs are constantly scanned and staff identified and developed and 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. The challenge is having the income to be able to employ an LPC Support Team, but there are options LPCs can consider supporting this.

Alignment is important to NHS structures is important. One option is to consider merging LPCs, another is forming 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. Other options are also available for consideration, but the main aim should be to create a structure, that has the resources to deliver the priorities identified above with the LPC having sufficient contractors to provide the required levy income to complete the necessary work.

C. Representation and proportionality

Size of the LPC committee

Some LPCs have reduced the number of committee members that they have, to drive better decision making and to reduce 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 how many committee members it should have, within a recommended range of 10-12 members whilst maintaining local proportional representation. 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. 11 would be an obvious number for CPH.

D. Finance and justification

The aim should be to reduce costs to enable to increasing contributions to PSNC without increasing the contractor levy, in other words there is no upward impact on contractor levy but a greater level of service and expertise because of pooling resources and economies of scale.

- o Levies will fund the LPC but yield greater income from a greater number of contractors.
- o Less operational costs experienced in the LPC due to one committee and one Chief Officer.

• Savings may come from centralising the LPC office, LPC Chief Officer and other employees, and possible reductions in meetings/ meeting times. However, the cost of sub groups will be significant and need careful management.
• There may be provisions required for redundancies and set up costs for the new central office.
• Where the LPCs have employees (with or without contracts of employment) professional employment law advice should be sought.

All the above must be considered when evaluating the options presented.

Options for restructuring LPCs –

There are five options that were considered by a joint meeting between chairs and CEO's of CPH and CPNY on Nov 1st considering the previous criteria. There are multiple appendices to this paper containing supporting details on the NHS structures, LPC finances, CCA checklists, services comparison, and constitution. Appendix 6 contains further detail of LPC functions in non-discounted options.

Options Discussed:

1. Minor boundary changes

a.) Over 70% of ICSs are already coterminous with upper-tier local authority boundaries, but there are a few areas where there are anomalies. This may mean a small number of contractors who no longer naturally fit with LPC representation to the NHS. Neighbouring LPCs could map these and agree how contractors may be better represented by adjusting LPC boundaries to rationalise the area they cover as part of the adopting the new model constitution.

Option vs Key questions:

Does our current structure match that of the NHS?
Humber matches the 4 ICS places in its footprint perfectly. NYorks nearly does the same for its 2 places. Both do match the functional geographic strategic partnerships and sub systems within the ICS. As such there is no scope for minor tweaks that would improve that significantly.

Are we the right size?
195 is close enough to 200 to meet this criterion given the often mentioned 'ballpark' nature of this number quoted during the RSG/TAPR process. No significant options in minor boundary changes would improve this notably.

Are we being effective and efficient with our finances.
No minor tweaks of significance available so no financial impact.

What are we called?
Already called Community Pharmacy Humber, this would change nothing.

How big is our LPC committee?
Minor tweaks would not impact on committee size. A need to reduce from 13 to 11 already acknowledged.

Additional PSNC/TAPR strategic questions:

- **Being able to meet increased contributions to PSNC, without having to increase contractor levies.**
  Minor tweaks, if available, would make no difference.

- **Having a representation and governance structure (LPC members) at a system level**.
  Minor tweaks, if available, would make no difference.

- **LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size.**
  [Any changes would be subject to the views of contractors via a local vote at a special meeting of contractors] Minor tweaks, if available, would make no difference.

- **To adopt a new model constitution.**
  A new constitution is to be voted on in any case.

Consideration:

Discussed by joint LPC meeting and found to be largely irrelevant, barring NY issues on craven with WY, but any tweaking would not derive any real benefits and still leaving 2 LPC's in place. **Option discounted.**

2. Merging LPCs

a.) This is when two or more LPCs formally merge to become one LPC with one committee, one Chief Officer and one support office and team.

Option vs Key questions:

Does our current structure match that of the NHS?
Humber matches the 4 ICS places in its footprint perfectly. NYorks nearly does the same for its 2 places. Both do match the functional geographic strategic partnerships and sub systems within the ICS. If the 2 LPCs were to merge they would match the entire ICS footprint.

Are we the right size?
Combined any new LPC would have 330 contracts, substantially in excess of the 200-ballpark figure.

Are we being effective and efficient with our finances.
Given the makeup of the ICS: its numbers of Places/PCNs/contractors and sheer size also its chosen ways of working, in subsystems and geographical partnerships, a merger may not provide much if any savings especially when set against reduced resources to address representation.

What are we called?
A new name would be required, Community Pharmacy Humber & North Yorkshire.

How big is our LPC committee?
A combined 11-person committee as per recommendations would take the place of 22 members.

Additional PSNC/TAPR strategic questions:

- **Being able to meet increased contributions to PSNC, without having to increase contractor levies.**
  There should be no need to increase contractor levies, but in-depth analysis of the representation support needed across the entire ICS, with a reduced committee/team, may impact elsewhere and minimise any potential for savings from the process.

- **Having a representation and governance structure (LPC members) at a system level.**
  Reduced pool of LPC members, 11 rather than 22, across a much larger LPC footprint. The ICS's use of subsystems and geographical partnerships increases the need for representation without any benefits of scale. The size of the geography does mean substantial variance in need and services across the ICS impacting on the experiential base required for a committee to represent from a limited pool of people.

- **LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size**
  [Any changes would be subject to the views of contractors via a local vote at a special meeting of contractors]
  A merged LPC would align with the ICS however at the risk of decreased representation as the ICS does its business in 2 distinct geographical partnerships.

- **To adopt a new model constitution**
  A new constitution is to be voted on in any case.

Consideration:

Discussed with an eye on both geographical scale of the current and new footprint and the direction of travel within the ICS. Referring to appendix 2 we can demonstrate that the ICS/ICPs are operating as at least 3 subsystems and 2 geographic partnerships with governance in place to support that.

This was considered as an option however the concerns regarding representation across such a varied and large geography, and the concerns over an 11-person committee being able to genuinely represent all the locales, made it doubtful, and even if chosen we would imagine there would be very little if any savings from the resources required.

3. Federating LPCs

a.) This is when two or more LPCs agree to formally work together with an overarching Board, whilst retaining the constituent LPCs underneath.
b.) This model has one Chief Officer, support office and team, however each LPC still retains its local identity and constitution.

Option vs Key questions:

Does our current structure match that of the NHS?
Humber matches the 4 ICS places in its footprint perfectly. NYorks nearly does the same for its 2 places. Both do match the functional geographic strategic partnerships and sub systems within the ICS. If the 2 LPCs were to federate they would match the entire ICS footprint.

Are we the right size?
Federated any 'new' LPC would have 330 contracts, substantially in excess of the 200-ballpark figure.

Are we being effective and efficient with our finances.
The existing committees and teams would maintain representation which will limit any savings, further under pressure as the levels of governance envisaged by the federation structure suggested in the toolkit would add workload and a lot of formal additional meetings with associated governance work.

What are we called?
The LPCs would retain their existing community pharmacy Humber and NY names however there would be an additional overarching federated structure that may require its own name?

How big is our LPC committee?
2 committees of 11 each and their existing governance/execs to manage LPC specifics issues plus additional overarching management structure for ICS level.

Additional PSNC/TAPR strategic questions:

- **Being able to meet increased contributions to PSNC, without having to increase contractor levies.**
  There should be no need to increase contractor levies, but with the additional governance requirements costs may rise and finances tighten.

- **Having a representation and governance structure (LPC members) at a system level.**
  The committees and teams are retained which should help with representation however the enhanced complex suggested governance could be restrictive.

- **LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size** *[Any changes would be subject to the views of contractors via a local vote at a special meeting of contractors]*
  A federated LPC would align with the ICS and as it's a formal federated model with overarching, officially recognised, governance it would constitute a significant change and need a contractor vote.

- **To adopt a new model constitution**
  A new constitution is to be voted on in any case.

Consideration:

The model put forward in the toolkit is very similar to merging, with the same drawbacks, if not more, and benefits. It was considered in the same vein, for further consideration, but with substantial risk and even less ability to save money even if the chances of representation were enhanced. The governance structures proposed under this model were considered to be unwieldy and restrictive and meant to push towards a merged option. As such with an ICS operating as 2 distinct entities a federated model, just like a merged one, is an answer in search of a suitable question, not an ideal fit.

4. Maintain the status quo

a.) This would need to be justified to contractors and agreed by them as part of adopting a new model constitution.

Option vs Key questions:

Does our current structure match that of the NHS?
Humber matches the 4 ICS places in its footprint perfectly. NYorks nearly does the same for its 2 places. Both do match the functional geographic strategic partnerships and sub systems within the ICS.

Are we the right size?
195 is close enough to 200 to meet this criterion given the often mentioned 'ballpark' nature of this number quoted during the RSG/TAPR process.

Are we being effective and efficient with our finances.
Yes, no changes other than PSNC increased levy which can be met from existing plans.

What are we called?
Already called Community Pharmacy Humber, this would change nothing.

How big is our LPC committee?
Currently 13.

Additional PSNC/TAPR strategic questions:

- **Being able to meet increased contributions to PSNC, without having to increase contractor levies.**
  Currently able to meet increased levy, shouldn't change.

- **Having a representation and governance structure (LPC members) at a system level**.
  As now.

- **LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size.**
  [Any changes would be subject to the views of contractors via a local vote at a special meeting of contractors] Already align with the subsystems and strategic geography.

- **To adopt a new model constitution.**
  Total status quo with no changes would include keeping the current constitution.

Consideration:

The meeting felt that this on its own, making no changes to adapt to the changing world was not fit for purpose and against the results and spirit of the contractor vote. **Totally Discounted.**

Preferred Option:

5. Collaborating more closely while maintaining the current geography.

a.) This would need to be justified to contractors and agreed by them as part of adopting a new model constitution.

Option vs Key questions:

Does our current structure match that of the NHS?
Humber matches the 4 ICS places in its footprint perfectly. NYorks nearly does the same for its 2 places. Both do match the functional geographic strategic partnerships and sub systems within the ICS.

Are we the right size?
195 is close enough to 200 to meet this criterion given the often mentioned 'ballpark' nature of this number quoted during the RSG/TAPR process.

Are we being effective and efficient with our finances.
Yes, no changes other than PSNC increased levy which can be met from existing plans.

What are we called?
Already called Community Pharmacy Humber, this would change nothing.

How big is our LPC committee?
Currently 13 but would change to 11 as per RSG vote.

Additional PSNC/TAPR strategic questions:

- **Being able to meet increased contributions to PSNC, without having to increase contractor levies.**
  Currently able to meet increased levy from existing plans and with a better planned approach to sharing ICS level attendances, some duplication will be removed improving efficiencies. A structure to share resources would aid NYorks in terms of services development, should it come as hoped, with mutual benefit to CPH.

- **Having a representation and governance structure (LPC members) at a system level**.
  As now for the Humber portion of the ICS. Reviewing the ICS level representative activity and sharing resources with NYorks for that activity should allow a more flexible approach to representation and fewer meeting clashes.

- **LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size.**
  [Any changes would be subject to the views of contractors via a local vote at a special meeting of contractors] Already align with the Humber subsystems and strategic geography, ICS level work can be better shared.

- **To adopt a new model constitution.**
  Adopting the new constitution would not impact on the ways of working envisaged, as they are entirely local, and wouldn't need any changes to the constitution to allow sharing resources and sharing ICS level engagement, as both are entitled to engage with the ICS. A robust working arrangement set of principles and ways of working would be established and agreed by both LPC execs during the 'implementation' phase.

Consideration:

A form of working that allows the flexibility to adapt to the changing world, the result of the RSG vote without the constrictions, demands and costs of the federated model. This approach aligns with the ICS's own structure most closely, and as requested by the TAPR toolkit demonstrates "*working closely with neighbouring LPCs to work out the best footprint for the benefit of local contractors."* We also felt it worthy of note that while the toolkit says, *"The NHS has previously indicated that the optimum is to have one voice for community pharmacy locally."* That is not something that the ICS has stated in this locale, the PCNs, Places and ICS have shown no issues with the LPCs representing their own geographies and community pharmacy at any level up to ICS level, even if both LPCs attend an ICS level meeting.

Appendix 2 shows several examples of the ICS's structural approach mirroring the 2 LPCs.

a.) This would need to be justified to contractors and agreed by them as part of adopting a new model constitution.

It is our understanding of the constitution that other than including this structure of the LPC, i.e. changes to 11 members, and other changes within the new constitution, that the contractor vote itself on the constitution would suffice. Though an explanation of the situation and model chosen would of course be provided.

All PSNC provided matters were considered for all options, and completely discounting 2 of the 5 options, left merging/federating or the current geography, with necessary constitutional changes from the RSG vote, and a more joined up approach to working with CP NYorks on ICS level matters. We feel that the preferred option could release some efficiencies, improve representation for all contractors and respect the result of the RSG contractor vote.

Appendix 4 shows each of the 3 main options rated against the CCA criteria, in our view.

Contractor engagement

Once these have all been discussed and an agreement reached by the full committee, the decision to call a special meeting of contractors must be carried by two thirds of the members of the Committee. It is recommended that 28 days' notice be given (minimum of seven clear days' notice is constitutionally required). This meeting can take place online. Further toolkit guidance is available and due to be updated shortly along with the final version of the new constitution, all should be available in time for the meeting on the 7th.

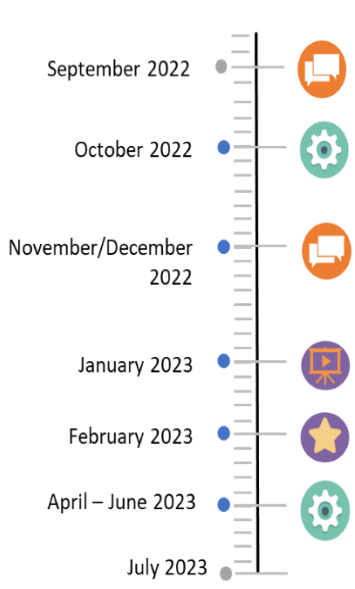
Decision making

An assessment template to 'mark' each of the options will be made available at the meeting to aid our deliberations.

	Assessment Criteria	Weighting (1-10, where 10 is most important)	Option 1: Same footprint new ways of working		Option 2: Merger		Option 3: Federate		Option 1: Same footprint new ways of working	Option 2: Merger	Option 3: Federate
			Score (10 = high)	Rationale / Comments	Score (10 = high)	Rationale / Comments	Score (10 = high)	Rationale / Comments	Score	Score	Score
Desirability	Matches NHS boundaries (ICB, having a representation and governance structure (LPC members) at a system level			Matches both ICS and functional ICP functional sub geographies		Concerns over 11 person committee covering 6 places, > 1500 square miles, 43 PCNs.		Concerns over 11 person committee covering 6 places, > 1500 square miles, 43 PCNs.	0%		
	Able to invest executive resource to undertake system and place-based work.			1 Geography, 2 sub-systems, 4 places, 237 PCNs, 195 CP for 11 person committee and 1 exec team.		1 Geography, 3 sub-systems, 6 places, 431 PCNs, 330/324 CP.		1 Geography, 3 sub-systems, 6 places, 431 PCNs, 330/324 CP. For 2x11 person committees PLUS 2 exec teams AND joint federated exec.			
Feasibility	Likely to have support of two thirds of each LPC committee locally and support at a special meeting of contractors			Yes		Less likely, harder sell to independents with loss of representation concerns.		Less likely, harder sell to independents over concept and complexity of the governance and an attached cost.			
Viability	Able to meet increased contributions to PSNC, without having to increase contractor levies			Capable		Capable		Capable but WM case not as solid			
	Size of 200 contractors or above			Very near, many times Prof M, regrep and others have said 200 is a ballpark figure not an exact.		Above		Above			
Local	Other criteria to be locally determined										

Critical path

This refers to the overall TAPR project timeline and the part this evaluation plays with it.



- Transformation explainer events for LPCs 13th September
- Transformation Toolkit part 1 published 14th September
- Employment matters portal launched 20th September
- Engagement with neighbouring LPCs to discuss boundaries - ongoing
- Representatives of LPC Conference 22nd September – levy and constitution discussions
- Indicative levy amounts for 2023/24 and beyond published
- LPCs meet to begin discussing the main questions
- Development of a proposal for the committee
- LPC meeting to discuss and agree boundaries, name, size
- Prepare materials for contractors and engagement plan to explain rationale for the new LPC model constitution, any boundary changes, proposed mergers and extension to the term of office to 30 June 2023
- Give notice of special meeting of contractors
- Hold special meeting of contractors with resolutions on model constitution and 3-month delay of current LPC term and then declare the results, inform NHS England and PSNC of existing LPC, new LPC, merged LPC or small changes to boundaries
- Develop implementation plan and prepare for LPC elections
- Move to implementation phase to include consulting with employees, financial convergence
- Existing terms of office end
- New LPC term of office begins

CPCF year 5 begins
ICBs live with delegated commissioning

Next steps

At the time of writing this paper we are expecting an impending update on procedures and processes around the SGM, the contractor vote and the comms expected to promote it. All should be available in time for the meeting on Dec 7th.

Current understanding has the committee choosing its preferred option, voting on it, and then putting that result forward to the contractors.

Should the preferred option be chosen, for example, the contractors would be voting on the extension to the committees' terms of service to summer 2023 and to adopt the new constitution which will incorporate the agreed changes: 11-person committee representing the Humber NHS geography, levy changes for PSNC and everything else updated within the new constitution. The ways of working with CPNY may or may not be included within the constitution as we've yet to see the final version. Regardless, the ways of working would need to be developed and are a committee level activity.

Appendix: 1 Key LPC Data

LPC name	Number of contractors	NHS Region	Relevant ICB(s)	Relevant Local Government Area(s) *	Partial Local Government Area (s)^	Alignment assessment	Potential solutions
CPNY	143	NEY	Humber & NY and WY Health & Care partnership, Lancs & Cumbria.	North Yorkshire City of York	Parts of NYCC sit within WY Health & Care partnership	Craven is NYCC but WY Health & Care partnership Part of ICB is covered by CPH	Minor boundary change or continue as was
CP Humber	195	NEY	Humber & North Yorkshire Health & Care Partnership	District of East Riding of Yorkshire City of Kingston-Upon-Hull Borough of North East Lincolnshire Borough of North Lincolnshire		All of Humber LPC sits within the HNY ICS Humber geographical area. CPNY sits within the NYorks geographical area of the HNY ICS.	CPH is fully aligned with the Humber geographical, functional, area of its ICS.

LPC name	Number of contractors	Levy per contract pa £	Office Costs Last FY £	Staff costs Last FY £	LPC member & meeting costs last FY £	Reserves (contractor) £	Reserves (others) £	Number of employed team WTE	Number of contract team
CPNY	143	£1,174.83	£14,900.00	£90,096.00	£19,091.00	£128,460.00	£39,692.00	Based on 40 hours pw as standard 2.35	3
CPH	195	£1454.03	£37,394	£195,083	£7,531	£243,449	£335,136 (mainly deferred NHSE funding)	Based on 40 hours pw as standard 3.08	6

LPC name	Number of contractors	Levy per contract pa £	Total levy pa £	PSNC levy 2022/23 £	PSNC levy 2023/24 £	Uplift in PSNC levy £	PSNC levy 2024/25 £	Uplift in PSNC levy £	Total uplift in PSNC levy £	Notes
CPNY	143	£1,174.83	£168,000.00	£40,744.00	£51,515.00	£10,771.00 (26.43%)	£61,162.00	£9,647.00	£20,418.00 (50.08%)	CPNY Yr. 1 levy increase due to rebalancing of £1,124.00
CPH	195	£1454.03	£283,536	£62,178	£69,815	£7,637 (12.3%)	£82,888	£13,073	£20,710 (33.3%)	Variance Yr1 to Yr2 due to rebalancing
Totals										

LPC name	Number of contractors	Number of CCA contracts	% of CCA contracts	Number of AIM contracts	% of AIM contracts	Number of Regional multiples* contracts	% of Regional multiples* contracts	Number of independent contractors	% of independent contractors
CPNY	143	63	44%	25	18%	0	0	55	38%
CPH	195	104	53.3%	20	10.2%	0	0	70	35.9%
Total									

LPC name	Number of contractors	Number of Committee members	Number of vacancies	Number of CCA reps	Number of AIM reps	Number of Regional multiples reps	Number of independent reps	Number of independent contractors	% of independent contractors
CPNY	143	11	1	4	2	0	4	55	38%
CPH	195	13	4	8	1	0	4	70	35.9%
Total									

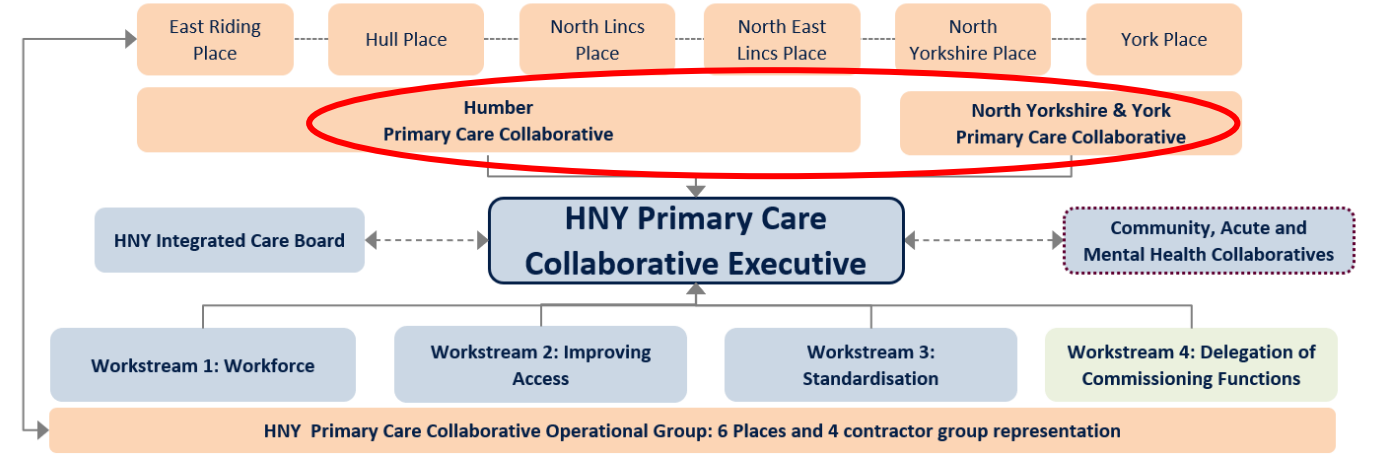
LPC name	Uses model PSNC constitution (Yes/No)	Notes on variances to model constitution (or n/a)	Provider company (Yes/No)	Other notes
CPH	Yes	N/A	No	Plan to adopt new model constitution following impact review.

Appendix: 2 Humber & North Yorkshire ICS Structural Data

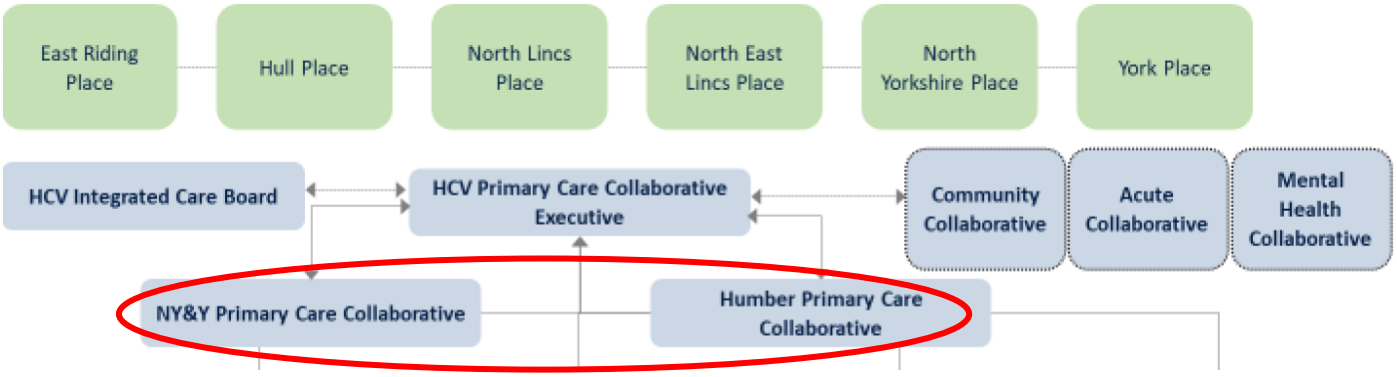
The Integrated Care Board

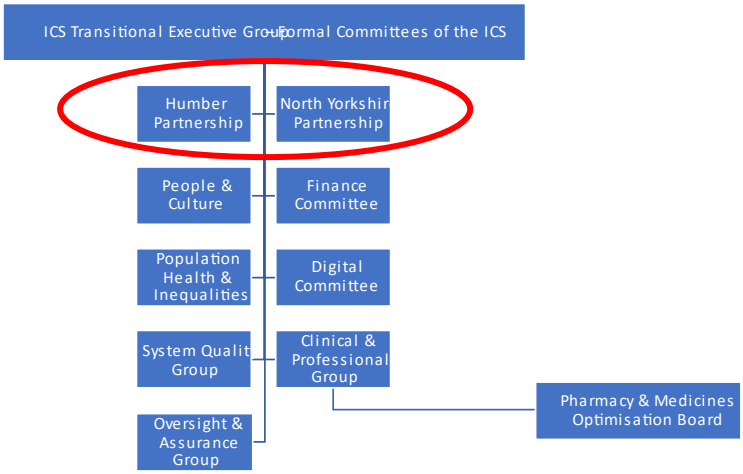
NHS
East Riding of Yorkshire
Clinical Commissioning Group

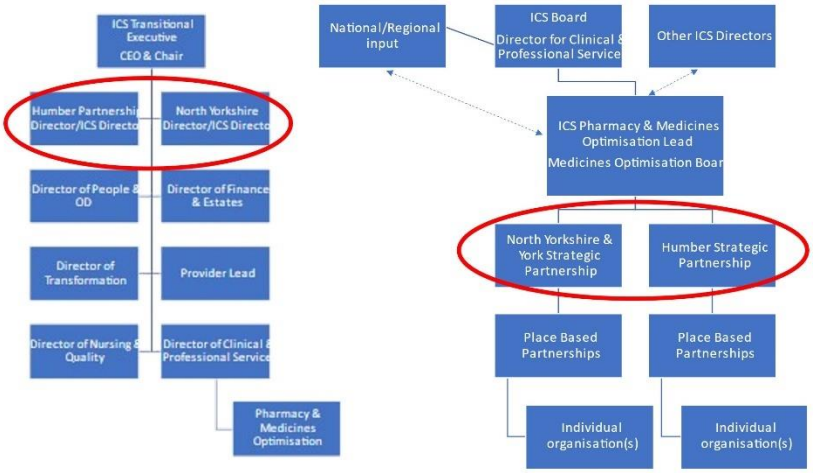
Primary Care Collaborative Governance Structure



Proposed Governance Structure







Roles and Responsibilities

Individual organisations	• **Trust Boards and CCG governing bodies retain full statutory duties and responsibilities for their own plans and performance**
Geographical Partnerships x2	• Assurance of delivery, quality, finance and transformation within place • Agreement of a shared plan • Identification and mitigation of risks • Delivery of operational plan commitments and longer-term strategy • Assured through quarterly whole-place reviews
HCV ICS	• Agreement of system actions and mitigation of risks to delivery, quality and finance • Agreement of allocation of system resources to support improvement action • Conduct of Place quarterly reviews, in partnership with NHSE/I
NHSE/I	• Co-ordination of Place quarterly reviews, in partnership with ICS • Enhanced oversight of challenged places / organisations, involving ICS • Agreement of tailored support packages, with ICS • Formal intervention in individual CCGs or Trust, only by exception, wherever possible with agreement of ICS

Extract from future PSNC regions briefing Nov22

Key	(1) NHS Integrated Care Board (ICB) Name	(2) Numbers of Pharmacy Premises	(3) Number of Independent Pharmacy Premises	(4) LPCs 'as-is'	(5) Estimated LPCs from July 2023	Notes
NHS North East and Yorkshire Region						
1	NHS Humber and North Yorkshire	324	104	2	2	Community pharmacy Humber Community Pharmacy North Yorkshire
2	NHS North East and North Cumbria	649	268	6	4	Community pharmacy Durham and Darlington Cumbria LPC Gateshead and South Tyneside LPC North of Tyne LPC Sunderland LPC Tees LPC
3	NHS South Yorkshire	311	85	4	1	Barnsley LPC Sheffield LPC Rotherham LPC Doncaster LPC
4	NHS West Yorkshire	543	245	1	1	Community Pharmacy West Yorkshire
Totals	4	1,827	702	13	8	

Recent ICS Job advert:

We are seeking to appoint three Directors of Clinical & Professional Services. Each will have ICS-wide responsibilities and overall responsibility for leading, developing and implementing clinical and professional duties across one of three health and care partnership sub-systems: North Yorkshire and York, Hull and East Riding, Northern Lincolnshire.

There are no plans for the 2 LMC's to change their borders.

Appendix: 3 CCA checklist

CCA LPC Matters - TAPR Special Edition

1. **Wherever possible, Contractors in an ICS footprint should be represented by <u>one</u> LPC.**

   1.1 The NHS and the ICSs have indicated that they wish to only collaborate with one voice for community pharmacy locally. We agree this is optimum.

   1.2 One of the key proposals accepted by the national ballot was for LPCs to review their boundaries in line with NHS integrated care systems changes.

2. **Local representative bodies should contain at least 200 contracts.**

   2.1 Proposal 36 of the RSG accepted by the ballot is "LPCs to more closely align with NHS Integrated Care Systems (ICS) and to reconsider their size (in terms of numbers of contractors represented) in line with the Wright Review recommendation that LPCs with a minimum of 200 contractors provide better value.

   2.2 Any changes would be subject to the views of contractors via a local vote, which might ultimately lead to 39-42 LPCs"

3. **One LPC may represent contractors across multiple ICSs.**

   3.1 There is no conflict in a LPC representing contractors with more than 1 ICS, so long as that the function and structure of the LPC does not prioritise one ICS contractors at the detriment to the other.

   3.2 This is an option for ICS footprints that contain less than 200 contractors to coalesce into one larger LPC and ensure benefit of scale can be achieved for the local contractors.

4. **There must be no net increase in levy payments from contractors to their local representative body.**

   4.1 As LPCs re-align to match ICS footprints, the overall contractor levy of the new combined entity should be no more than the combined levies of contractors from the previous structures.

   4.2 Proposal 10 of the RSG "PSNC will also need to better support LPCs to make efficiencies to release this funding without increasing the overall burden on contractors" so we do not support any net increase in the levy collected from local contractors.

   4.3 LPCs must be able to deliver the increased PSNC levy and continue to be the local voice of contractors within the current levy payments.

   4.4 Before any consideration of change in LPC structure or size, contractors must have visibility of a full breakdown of costs.

5. **Adoption of new template constitution by all LPCs** *(Debated once the LPC gets sight of the final document)*

CCA Guidance Compliance Check		**This Option: Comment**
Q1	1.1	
	1.2	
Q2	2.1	
	2.2	
Q3	3.1	
	3.2	
Q4	4.1	
	4.2	
	4.3	
	4.4	

This checklist will be part of each option to aid in assessment against CCA criteria.

Appendix: 4 CCA checklist by Option.

Option 2: Merge.

CCA Guidance Compliance Check		This Option: Comment
Q1	1.1	No such comments locally.
	1.2	Matches ICS but with less resource.
Q2	2.1	330 > 200
	2.2	Would need a vote.
Q3	3.1	N/A
	3.2	N/A
Q4	4.1	Met.
	4.2	Probably.
	4.3	Limited savings potential.
	4.4	Would be calculated.

Option 3: Federate.

CCA Guidance Compliance Check		This Option: Comment
Q1	1.1	No such comments locally.
	1.2	Matches ICS.
Q2	2.1	330 > 200
	2.2	Would need a vote.
Q3	3.1	N/A
	3.2	N/A
Q4	4.1	Met.
	4.2	Probably, some federated additional costs.
	4.3	Probably, some federated additional costs.
	4.4	Would be calculated.

Option 5: Collaborate. [Preferred]

CCA Guidance Compliance Check		This Option: Comment
Q1	1.1	No such comments locally.
	1.2	Matches ICS and subsystems.
Q2	2.1	195 is within acknowledged 'ballpark'
	2.2	No change, but within the constitution vote.
Q3	3.1	N/A
	3.2	N/A
Q4	4.1	Met.
	4.2	No increase, some joint working saving potential.
	4.3	No increase, some joint working saving potential.
	4.4	Within existing budgeting.

Appendix: 5 Services

There are varying rates of levy's between LPCs, just as there are varying opportunities to get services available. For context here are lists of the services available in CPH and in elsewhere with fewer opportunities.

Worth noting that in 20/21 CPH levy income was £283,356 and after paying PSNC the net levy to the LPC was £221,358. For that investment contractors received local service income of at LEAST £707,725 and likely more than £1m due to outsourced services with unknown income totals. The last year before Covid and outsourcing had services income at over £1.3m, 2018/19, meaning we have some comfort in claiming services as being worth over £1m. Which means that for **every £1 in levy's paid to this LPC**, even if it all went on services and not <u>everything</u> that we do, the contractors receive a **return of between £3.20 and £4.52**+ for that levy, at least.

Area	Services	Commissioner
Hull	Methadone/Buprenorphine – Supervised Consumption Hull	Hull ReNew (CGL)
Hull	Needle Exchange Hull	Hull City Council
Hull	EHC Ulipristal Hull	CHCP
Hull	EHC Levonorgestrel Hull	CHCP
Hull	Minor Ailment Service Hull	NHS England on behalf of Hull CCG
Hull	Medication record charts for carers Hull	NHS England on behalf of Hull CCG
Hull	Smoking Cessation NRT/Voucher Hull	CGL from 01/10/19
Hull	Smoking Cessation Varenicline Hull	CGL from 01/10/19
Hull	Palliative Care Hull	NHS England on behalf of Hull CCG
Hull	PURMS (Pharmacy Urgent Repeat Medication Supply) – Hull	NHS England on behalf of Hull CCG
Hull	Point of dispensing Intervention Service (PODIS) – Hull	NHS England on behalf of Hull CCG
Hull	TB DOT	NHS England
Hull	Medication Administration Support Service (EL23)	NHS England
Hull	Out of Hours Rota	NHS England
Hull	Blood Pressure Testing Service	NHS England on behalf of Hull & ER CCG
ER	Buprenorphine/Methadone – Supervised Consumption ER	ER Council
ER	Needle Exchange ER	ER Council
ER	Medication record charts for carers ER	NHS England on behalf of ER CCG
ER	EHC Ulipristal ER	ER Council
ER	EHC Levonorgestrel ER	ER Council
ER	Minor Ailment Service ER	NHS England on behalf of ER CCG
ER	NHS Health Checks ER	ER Council
ER	Palliative Care ER	NHS England on behalf of ER CCG
ER	Point of dispensing Intervention Service (PODIS) – ER	NHS England on behalf of ER CCG
ER	PURMS (Pharmacy Urgent Repeat Medication Supply) ER	NHS England on behalf of ER CCG
ER	Smoking Cessation NRT Voucher ER	ER Council
ER	Smoking Cessation Varenicline ER	ER Council
ER	Medication Support Service (MSS) ER (Replace EL23 for ER only)	NHS England
ER	Out of Hours Rota	NHS England
ER	TB DOTs (Directly Observed Therapy)	NHS England

ER	Blood Pressure Testing Service	NHS England on behalf of Hull & ER CCG
NEL	ACT (Advice, Contraception & Treatment) NEL Levonorgestrel	NEL Council
NEL	ACT (Advice, Contraception & Treatment) NEL Ulipristal	NEL Council
NEL	PODIS - NEL	NHS England on behalf of NEL CCG
NEL	Minor Ailment Service NEL	NHS England on behalf of NEL CCG
NEL	Smoking Cessation NRT Voucher NEL	NEL Council
NEL	Out of Hours Rota	NHS England
NEL	Supervised Consumption & Needle Exchange NEL	We Are With You
NEL	Out of Hours Palliative care service	NHS England on behalf of NEL CCG
NEL	Palliative Care	NHS England on behalf of NEL CCG
NL	Minor Ailment Service NL	NHS England on behalf of NL CCG
NL	Needle Exchange NL	Agencia: renamed We Are With You
NL	Supervised Consumption NL	Agencia: renamed We Are With You
NL	Palliative Care NL	NHS England on behalf of NL CCG
NL	Out of Hours Palliative care service	NHS England on behalf of NL CCG
NL	TB DOT	NHS England
NEL	Out of Hours Rota	NHS England
NL	PODIS - NL	NHS England on behalf of NL CCG

Plus pilots for: oral contraception supply, UEC referral to CPCS, COPD, Walk in CPCS and funded PCN lead time.

In comparison:

Public Health North Yorkshire County Council

- • Supervised Consumption
- • Needle Exchange
- • Sexual Health
- • Smoking Cessation North Yorkshire – (County Council Inhouse Service)
- • Flu Vaccination (NYCC Staff)

Public Health City of York Council

- • Supervised Consumption
- • Needle Exchange
- • Healthy Start Vitamins supply
- • Champix Dispensing

Vale of York CCG and North Yorkshire CCG

- • Palliative Care

Hambleton District Council

- • Sharps Disposal

Consilient Health Ltd.

- • Vitamin D identification service pilot (completed by year end)

Appendix: 6 Further Details of LPC 'Options' and functions -

2 - Merged LPCs

It is not unusual for two LPCs to merge with a number merging in recent years following CCG boundary changes.

Outline functions

Committee

- To appoint and manage the Chief Officer. The Chief Officer can then recruit other staff.
- To be responsible for the finance, financial management and budget.
- To approve and monitor the LPC business and strategic plan.
- Overall responsibility for the LPC office and the services.
- Responding, with central support, to statutory consultation by NHS England.
- Local negotiations with office support.
- Representation at the LPC conference.
- Delivery of all duties under the LPC constitution and governance framework including annual report and accounts.
- Recognised by NHS England and the ICS as the local committee representing contractors in its area on NHS matters

LPC office

- Contractor communication including website, newsletters, and events.
- Organisation and secretarial support (agendas and minutes) for LPC and subgroup meetings.
- Advice and information point including written guidance and briefings for contractors, support for individual contractors when required.
- Media and local lobbying.
- Supporting local negotiations and contracting.

Representation

- Represents the contractors covered by the LPC to external organisations.
- Represents community pharmacy with local health organisations and political organisations.
- The contact point for all communications with individual LPCs.

3 - Federated LPCs

Under this model management and administration is provided centrally whilst retaining the individual LPCs that fund the new tier.

Outline structure

• Some overarching structures form a limited company (e.g. Wessex LMCs and London LMCs) to provide the support services to limit liability; others continue like their constituent committees as unincorporated associations.

• The management of the administrative tier is important- this is best achieved by a secretariat or Board consisting of the chairs and vice chairs of each of the constituent LPCs.

• This group will have responsibility for the appointment and performance management of the Chief Officer and is accountable to the constituent LPCs.

• The Chief Officer is accountable to the Board.

• The Board needs to vote on the appointment of a chair from amongst the board members to chair meetings. The chair would normally be non-voting (casting vote only).

• The Board will be responsible for the recruitment of the Chief Officer.

• The Chief Officer will, with Board approval, appoint additional staff to complete the administrative team.

• The constituent LPCs remain the bodies recognised as the LPCs. The new tier although not officially an LPC could have a trading name such as "*Several Shires LPC*" representing the (example) 500 pharmacy contractors in A shire, B shire and C shire".

• All communications and business would be done from and with the *Several Shires LPC* so a contractor wanting to contact the LPC for his area would contact the central office as the individual LPCs no longer need offices or an individual LPC Chief Officer.

• Each LPC would have a Chair and Vice Chair as required by the LPC constitution- the Treasurer and Chief Officer would be at the central office.

• The individual LPCs would still meet although this would be to conduct the basic statutory duties of an LPC

• Consequently fewer meeting may be needed; no changes to the LPC constitution are needed although the LPC could decide that it needs fewer members.

Outline functions Board

• To appoint and manage the Chief Officer and through him other staff.
• To be responsible for the finance, financial management and budget.
• To approve the business plan.
• Overall responsibility for the central office and the services for the constituent LPCs Central office.
• Delivery of services to LPCs.
• Contractor communication including website, newsletters, and events.
• Organisation and secretarial support (agendas and minutes) for LPC meetings.
• Chief Officer or deputy attends meetings of all LPCs.
• Organisation and secretarial support for board meetings.
• Advice and information point including written guidance and briefings for contractors.
• Support for individual contractors when required.
• Media and local lobbying.
• Leading/ supporting local negotiations with LPC chair.
• Business development activity to create opportunities for contractors.

Representation

• Represents collectively the LPCs to external organisations.
• Represents community pharmacy with local health organisations and political organisations.
• The contact point for all communications with individual LPCs including:
    - Responding, with central support, to statutory consultations by NHS England.
    - Local negotiations with central support
    - Representation at the LPC conference
    - Representation on the Board
• Delivery of all duties under the LPC constitution and governance framework including an annual report and accounts (delegated to the central office as appropriate) and financial control
• Recognised by NHS England and the ICS(s) as the local committee representing contractors in its area on NHS matters.
• Whist certain administrative functions can be delegated to the central body, the authority and power of the LPC resulting from statutory recognition cannot.

---

5 – Collaborating while Maintaining the current geography.

All the functions of a merged LPC, a normal LPC, linked to the Humber geographic partnership of the ICS. In addition there would be a clear 'way of working' agreement to share representation and resources at ICS level with CPNY, while retaining responsibility for our own geographies. Other RSG voted recommendations on PSNC increased Levy and planned increases in contractor levy, accepting the new constitution, reducing the committee size would all be accepted.

Outline functions
Committee
- To appoint and manage the Chief Officer. The Chief Officer can then recruit other staff.
- To be responsible for the finance, financial management and budget.
- To approve and monitor the LPC business and strategic plan.
- Overall responsibility for the LPC office and the services.
- Responding, with central support, to statutory consultation by NHS England.
- Local negotiations with office support.
- Representation at the LPC conference.
- Delivery of all duties under the LPC constitution and governance framework including annual report and accounts.
- Recognised by NHS England and the ICS as the local committee representing contractors in its area on NHS matters

LPC office
- Contractor communication including website, newsletters, and events.
- Organisation and secretarial support (agendas and minutes) for LPC and subgroup meetings.
- Advice and information point including written guidance and briefings for contractors, support for individual contractors when required.
- Media and local lobbying.
- Supporting local negotiations and contracting.

Representation
- Represents the contractors covered by the LPC to external organisations.
- Represents community pharmacy with local health organisations and political organisations.
- The contact point for all communications with individual LPCs.

Appendix: 7 Constitutional references

LPC-

Amendment of Constitution

19.1. This constitution may be amended only in accordance with the procedure in this section.

19.2. The Chief Officer shall, if requested so to do by not less than two-thirds of the members of the Committee or one-third of the pharmacy contractors summon a special general meeting of the contractors, and shall give not less than seven clear days notice to each pharmacy contractor, stating the time and place of the meeting and the proposed amendments of the Constitution for which it has been summoned.

19.3. The meeting summons will also include a voting form to allow the contractor to register a vote on the amendment by returning the form to the LPC Chief Officer at any time before the vote is taken at the meeting.

19.4. In this paragraph a pharmacy contractor is to be interpreted as one contractor for each of the pharmacy contractor premises he owns in the area for which the Committee is formed.

19.5. Any amendment to the constitution must be carried by a two-thirds majority of the total votes cast.

19.6. The Chief Officer shall at the same time as issuing the summons under Paragraph 19.2, notify the Chief Executive Officer of the Pharmaceutical Services Negotiating Committee of any proposed amendment to the constitution, and shall include a copy of the summons.

PSNC – (2018)

Functions of the PSNC Subject to paragraph 14.4 the functions of the PSNC are:

3.1 to secure for Chemists the best possible contractual terms and remuneration in respect of National Health Service pharmaceutical services and Directed services provided by them.

3.2 To represent, protect and serve the interests of all Chemists and to develop community pharmacy services to the benefit of Chemists.

3.3 To negotiate, as representative of the general body of chemists with the Department of Health and Social Care and NHS England, the conditions of service and the remuneration for the dispensing of National Health Service prescriptions and the provision of the pharmaceutical services and Directed services under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations and any Directions issued by the Secretary of State.

3.4 To represent Chemists in discussions and negotiations with other Government Departments and other bodies.

3.5 To consider, support or oppose legislation, proposed or otherwise, affecting Chemists in connection with the National Health Service Pharmaceutical Services and Directed services.

3.6 To check and use all reasonable endeavours to agree each month with the Department of Health and Social Care the prices to be used by the NHS Business Services Authority for pricing National Health Service prescriptions.

3.7 To maintain as the agent of Local Pharmaceutical Committees in England and Wales a Pricing Audit Centre to check on a sampling basis on behalf of Chemists the pricing and accounting of National Health Service prescriptions and to carry out such other functions as the PSNC may direct.

3.8 To provide an advisory service to Chemists on matters relating to the National Health Service.

3.9 To advise and support Local Pharmaceutical Committees in negotiations with local authorities and other commissioners.

3.10 Generally to do all other things necessary to preserve, protect and further the interests of Chemists in connection with the provision of the National Health Service Pharmaceutical Services and Directed services.

3.11 To carry out such administrative activities as are necessary to perform the functions described in this paragraph.

13.2 Special Conference of Representatives of Local Pharmaceutical Committees
The PSNC shall, if requested in writing, by not less than 25 Local Pharmaceutical Committees, call a Special Conference of Local Pharmaceutical Committee Representatives.

14.2 PSNC is funded by Chemists.
14.3 The funds are collected through Local Pharmaceutical Committees.