**Minutes of LPC meeting November 2020**

**Apologies:** Peter Badham (AIM)

**In Attendance:** Will Pearce- treasurer (WP), Andrew Lane- chair (AL), Neetan Jain- vice chair (NJ), Gary Barber- IND (GB), Sam Bradshaw- support officer (SB), Rebecca Myers- AIM and Partnerships Manager (RM), Mohammed Rahman- CCA (MR), Tufael Siddique- CCA (TS), Etisham Kiani (EK), Wayne Ryan- CCA(WR), Sophie Cutler- CCA (SC), Vas Alafodimos -CCA (VA),

**Guests: None**

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| Welcome and introductions |  |
| Contracts | **TS declared a conflict of interest and left the meeting.** The contract application for an internet pharmacy from cheltpharm ltd was discussed and comment given on the proposed reply.The additional points were made.1. Committee wanted NHSE to assure that equitable service would be given for patients nationwide
2. A request that Cheltenham Borough Council be asked to notify us if change of use planning application submitted

RM to action.**TS re-joined meeting** |
| Officer reports | AL- report on actions within national groups NPA and PSNC. Update on progress with the Wright Review work. A review steering group has been set up with 4 CCA, 2 AIM and 4 independent members.SB- Support given over the last 2 months to the following projects:KickstartGP CPCS trainingPCN leads- still need a lead for Quedgeley group. SB to work with WR to ask one of the staff at Quedgeley Boots if they will take the role.TCAMS engagement and monitoringFlu and care homes/carers fluIt was noted that Sam had been supporting the CCG/GCC team in engaging care homes staff for flu vaccination, identifying pharmacies with stock to direct carers to and booking pharmacists to deliver offsite clinics. The CCG has provided reimbursement for some of Sam’s time to do this.RM- Clarity of flu service and work undertaken with CCG and GCC. Discussion about vaccine availability and service delivery, offsite vaccination clinics and care homes. PCN data was reviewed for over 65’s. RM to ask Rachel if they have the same data for risk groups under 65.Feedback to be given to PSNC- pharmacies have a quota for flu vaccines- they are coming in at 10 per order with a cap of 25 per month. Alliance has a ‘low account surcharge’ of £300 so cannot use them as a ‘one off’ supplier without incurring significant cost. There is not equitable access to stock for pharmacy – example given was that the trust were able to order 10,000 vaccines whereas we can only order 25. Example given GPs had access to vaccine well before pharmacy- several patients on pharmacy waiting list had cancelled as they had visited the surgery for vaccination instead despite it not being their preferred option as they didn’t want to risk pharmacy not getting vaccine. Pharmacies checking supplier websites multiple times a day on the off-chance more stock released- then it’s a matter of grab it quick while it is there and hope it comes in.NJ gave a verbal report about the PSNC conference and mentioned the CPCS video that Avon had produced as a good resource. |
| Treasurer update | 2 month levy holiday confirmed and has been appliedWP gave update in advance of AGM and shared accounts. Committee happy, RM to share accounts prior to AGM |
| ICS | ICS workforce document reviewed prior to CCG submission to NHSE. The following points were made. RM to ensure that all are included in final submission* There is no immediate benefit to contractors for ‘sharing’ staff or having pharmacists work across multiple sectors. This model does not fit with the contractor model of community pharmacy.
* Already lost significant workforce to primary care
* Multisector role may help to encourage future workforce, but only if staff have access to equitable salary, pensions, benefits etc. For current workforce it will be difficult to transition into a multisector role.
* Would be better to bring services from primary care into community pharmacy rather than take staff out of community pharmacy into primary care. That way the additional benefits of improved access, longer hours, close to community, walk in service etc. can also be utilised in community pharmacy
* Need to have ££ investment in training
* More long term cost to community pharmacy
* Community pharmacy funding at present does not ‘encourage’ or allow investment in technician training
* If an increasing role for technicians can be found (e.g. able to use PGDs) then this would allow CP to expand service offering and encourage training
* Concern about the ‘one way’ draw of staff, funding and resource into Primary Care

Focus should be on workload coming from primary care into community pharmacy rather than taking staff from CP into General Practice* Build on CPCS to pull all minor ailments consultations into CP with proper funding and clinical pathways- e.g. PGDs for treatment options or IP lead service
* Second pharmacist into pharmacy who does ‘NHS’ work for PCN, funded by PCN- pharmacy becomes the clinic on the high street

Look for funding within the ICS for piloting alternative models- look for 3 or 4 things that IPs could do from a community pharmacy based on the Gloucestershire Strategic Objectives from the JSNA. This would be capacity releasing for the GPs and could deliver clinical work at high value (e.g. respiratory/asthma)Pre-registrationExpose pre-reg pharmacists to a higher standard of clinical roles in pharmacy. Ensure protected learning time, look to involve the pre-reg in services, vaccinations etc-May be easier to recruit overseas candidates post Brexit.Community pharmacy needs to be more attractive in the first 1-2 years post qualification- develop services that are unique to community pharmacy that will attract candidatesLots of pressure in CP- not seen as a desirable job- long hours, targets, stress, primary care role seems easier Suggest training in managing workload/work pressures, delegation, using staff more effectively etc.Technicians- pharmacy needs to be paid to train technicians if we are being asked to train them for the NHS- could we push back to PSNC the suggestion of ‘Training premises’ with a training grant similar to GP training practices. Explore this further.Look at consultant roles- respiratory would work in community as well as in hospital, so would diabetes.Everything suggested needs appropriate funding streams- not existing funding streams as these are already in place to replace lost income from the core contractAttracting people to the county* Attractive clinical service models
* Drive innovation
* Local partners for wellness/wellbeing/fitness (e.g. Glos rugby or FOD activities)

Funded PCN lead rolesOther suggestions* Medicines reviews done in PCN in GP surgery could be done in CP (remote working?)
* Allow pharmacists access to primary care pathway for training but keep in community
* PSNC looking at vaccination services plus technicians
* PGDs for minor ailments (local otoscopy training)
* Prioritise referrals from GP to CP- drive CPCS then build serives oth framework

RisksInsurance for prescribers- IPs only insured to a level, will NHSE pick up the balance of liability when undertaking NHS work. This is a barrier to service provision |
| DMS | No update yet available. Due to become an essential service in January 2021. Review at next meeting. Our local TCAMS template is a bit odd- not sure how this will compare to the national service template. RM to chase NHSE for any information about DMS service framework |
| GP CPCS | Training delivered FTF at Aspen centre. No service delivery since training. RM and SB to chase with Louise. RM to chase Fiona Davenport for information on national rollout.Committee discussed possibility of using an employed role to engage- based on Judith Avon model. VA gave feedback about roll out in Avon areaDiscussed using the PCN leads for roll out within their PCN area (funded). Concern that they may not be the right people to use or that they may not be able to be released due to workload |
| Flu | Reviewed over 65’s flu delivery figures from the CCG. Uptake looks to have exceeded expectations. Most flu issues covered earlier- no further comments.  |
| PQS level 2 | No data available. PCN leads are meeting monthly on zoom and have sent questionnaires to all pharmacies. Some PCN leads are arranging meetings with their PCNs. Meetings must happen in January in order for pharmacies to claim their PQS points. |
| PSNC update | From Sian Retallick* Feedback about flu vaccines and equitable access
* No further information about DMS
* PSNC still working on Covid funding
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