

LPC Conference 11th March 2009

2009 Conference speech by PSNC CEO Sue Sharpe

Chris has outlined for you the main priorities for PSNC this year. The White Paper set out the government's policies for development of the services provided by community pharmacies. Bringing those policies to fruition is our greatest challenge. Most of the proposed new services are those we had been advocating. So when, at the dinner last year, Dawn Primarolo said she thought we would be pleased, she was right.

We were delighted that in the White Paper there was a clear acknowledgment of the need for some of the new services identified to be available everywhere, and for introduction of the Designated Enhanced Service or DES, perhaps first for minor ailments.

We are in negotiation again.

Our negotiations this time are in a different form from those leading to the 2005 contractual framework. The tripartite negotiations with DH and the NHS Confederation have been replaced, so far as they relate to implementation of new White Paper actions, with bilateral negotiations with NHS Employers, who are in turn given a mandate by DH to implement policy on specific actions.

The work is still in its early stages. It will be a 3 to 4 year project. Unless a change of government next year leads to a change of direction. But that – the change of direction – seems unlikely.

PCTs

NHSE, and the PCTs they represent, will increasingly have more control over use of pharmacies for service provision. In 2005 we were able to ensure a strong national contract, and we will endeavour to continue to deliver the consistency and certainty that contractors need through a core nationally agreed and funded framework. But government policy means local commissioning of services from all NHS care providers will increase. So for us at national level, and for you at local level, establishing credibility and collaboration to effectively promote use of community pharmacy for service provision is essential.

The government has recognized that PCTs lack commissioning skills. In pharmacy we have seen this very clearly. The organizational structure and the competencies of the people tasked with considering community pharmacy service commissioning (too frequently people employed for their expertise in prescribing cost savings) – they have not been fit for purpose. The NHS wish for innovation in service delivery has been frustrated by the lack of competency in PCTs. The government has recognized this.

PCTs' Assurance Reports for the last year have all now been published, and should be on their websites. They show that there is a lot to be done. I have been to a couple of PCT websites recently. Together, the JSNA and the Assurance report provide an extensive resource to be mined for target areas where pharmacy services

can make a difference. This year PCTs performance management will include primary care commissioning.

So the environment is likely to be good for pharmacy to make a push to provide more local enhanced services.

I do not underestimate the difficulties you can face. They include in some cases unmanageably complex tender documents, and a skeptical community of contractors, disappointed by previous experience. Some LPCs have also encountered real opposition within PCTs.

Most of you have stories to tell of poor commissioning or administration by PCTs. And sometimes the PCT responds with claims of poor delivery by pharmacies. We all need to move on from this – understand what has gone wrong and make progress for the future.

It is vital to get over negativity wherever it lies. Whilst the nationally agreed services and funding will continue to be the foundation for the community pharmacy business, local services contracting will become increasingly important as a source of revenue. Local contractors and LPCs will have greater responsibility than before for identifying and negotiating their role as service providers.

With an increasing focus on local service commissioning we need to ensure that the workload burden for independent pharmacy contractors remains manageable. It is already very heavy, and the independent today does not have the time and capacity to deal with large and complex documentation. We are committed to support independent contractors, all contractors. Manageability is vital.

Chris referred to the change from control of entry to a PNA based entry test. This too will strengthen the role of PCTs. For us it is far better to support development of community pharmacy that entry is planned according to locally identified need, rather than unplanned free market entry. There are risks. PNA based planning must be robust. PCTs must be accountable for their decisions, and poor performance by PCTs must be appealable. What about 100 hour and internet pharmacies, and the other two exemptions – large shopping centres and health centres? Will they go? We do not yet know. They seem as anomalous in a system of proper needs based planning as they are under the control of entry system. Go they should.

Introduction of PNA based planning will mark a shift in how PCTs relate to community pharmacy. The global sum, which today accounts for roughly half total funding, will also be devolved to PCTs. Although fees and allowances for essential services will continue to be set nationally, the cost will fall on PCT budgets.

With their greater role, which will include increased sanctions for poor performance, we can expect far greater interest in pharmacy from PCTs. So we need – you need – to ensure their perspectives are positive. This is the time to lay down the foundations for constructive working in the future. It is not enough to lament poor relationships. We need to do whatever it takes to change them and make them positive.

I am delighted that Jonathan Mason, the Clinical Director for pharmacy, is joining us this afternoon. We can talk to him about what needs to happen on both sides to truly enable the pharmacy service to flourish.

Funding

Community pharmacy national funding for 2009-10 will continue to be based on the present system, with adjustments made in accordance with the formula. You are all familiar with it – it includes the adjustment for the GDP deflator, staff salary increases, volume, efficiency, and regulatory burden.

This time last year the funding position was grim indeed. In part this was caused by the reduction in Cat M prices and reductions in practice payments to counter-balance over delivery of funding for the first 6 months of the financial year. But something else was wrong. We did not believe there was any major omission in the cost base used to determine funding – we had picked up all the relevant costs reported, using a methodology used for many years.

So what was wrong? I think it was the decline in non NHS turnover. We did a survey of 2800 pharmacies. NHS turnover now accounts for 90% of total. At this level there is not the level of non-NHS income to support apportionment of any significant level of costs to front-of-shop activity. The result of this survey played a major role in persuading the minister to increase funding by £150m from October. And that was a lifeline for many pharmacies.

But it is more significant than that. It means that pharmacies are now NHS businesses. The figure has an immense effect on PCTs as they understand the implications. And they are always surprised when they hear it for the first time. Only rarely does the visual appearance of pharmacies match this reality.

That £150m was a lifeline, and in the face of the current economic problems it was a remarkable statement of faith by the minister. It has been added to the base funding so will be incorporated into the funding adjustment for 09/10.

We agreed to a new cost inquiry, and are developing the proposals with the Department of Health. It will be conducted later this year, so the funding arrangements for 2010/11 may change in the light of the results.

We have stated very clearly to the Department that the new inquiry must cost the pharmacy service we all want for the future. If the rewards are not available, the service will not be there. We have the first meeting of the Cost Inquiry steering group in the diary for April. In addition to members of the Committee we will have two experts advising PSNC to ensure the methodology fully captures what we need.

Meanwhile, what about funding from April. The 30p supplement to Practice Payments ends this month. Practice payments will be paid at 70.9p per item. The item fee will remain at 90p. Although the results of the margins survey will not be known for some months, at this point we do not expect any other major changes. The destabilizing factors we saw back in 2007-8 will not, we believe, recur. But the market in pharmaceuticals is not stable and predictable, and it is not possible to be certain what changes may affect us.

Which brings me to supply issues

It has been a turbulent year for supplies. Our margins surveys that provide the data used to set Cat M prices also track prices paid for branded medicines. The fall in

value of the £ against the euro led to a significant drop in availability of PI medicines. That led to some supply problems as manufacturers took time to increase production to cope with increased demand for UK stocks.

It led also to increased parallel exporting. Contractors large and small get offers to buy small or large quantities of target medicines. The trade has driven shortages in UK stocks. Manufacturers provide data to support their arguments that they are releasing more stock into the UK market than is needed to meet prescribing demand here. Exporting is a major driver of the real problems contractors are experiencing as increasing numbers of lines are on quota.

PSNC's role is to support NHS community pharmacy contractors in that role. We are not here to support exporting of stocks to service other countries. Indeed where this activity makes the job of our contractors more difficult we strongly disapprove of it.

And it is worse. We have seen more and more manufacturers introduce new distribution arrangements for their products. This is in large part a reflection of their wish to control stocks and manage supplies. So it adds yet more burden on pharmacy contractors. And we are not able to dictate wholesale supply arrangements.

It could be worse still. In recent months there has been press interest in supply shortages. Some with rather blinkered vision think this is a good thing and will put pressure on manufacturers to increase supply levels. My fear is different. The potential for reputation damage to community pharmacy if pharmacy contractors are exporting medicines needed by UK patients to turn a quick buck, or euro, is immense. At a time when we need to develop our role as trustworthy providers of NHS services, it is hard to think of something more damaging than this. Pharmacy must be an ethical business. Any contractor that diverts supplies intended for UK patients elsewhere will contribute to damaging our standing.

Reimbursement

The supply chain on which pharmacies depend has changed almost beyond recognition. Agency, DTP, limited wholesaler schemes. All have added complexity, workload and cost. The impact has been to drive out competition, drive down margins, and drive up costs. Where will it end?

We have no control over the companies further up the supply chain, but we do ensure that the effect of what they do is understood by the Department of Health, and that the financial impact is calculated.

So I want to confirm how we do that.

The annual margins survey uses invoices collected from a representative sample of independent pharmacies. The sampling methodology has developed during the four years. This year we will use 10 contractors' invoices for each month from April 08 to March 09. From the invoices we collect we extract prices paid for a sample of medicines, both generic and branded medicines, together with discount terms.

The resulting prices are scaled up to the total market, and this allows us to calculate the amount of profit in generics purchasing for the year, and, at present, the loss on brands. Last year the loss on brands was c£50 million

That loss on brands is offset by allowing more profit on generics. This is not ideal, and we are in discussion to see how we can distribute profit more equally among purchases. But you will understand that if we reduce the discount scale so there is profit in branded medicine purchases, then we need to reduce the profit in generics to provide £500m purchase profits.

Would manufacturers respond by further reductions in the supply terms? What would happen to generics? We have seen in the last four years just how many factors there are that influence how contractors source products and what they have to pay.

What we must do is to ensure that we monitor what is happening, and ensure it is taken into account. To make sure that the average independent contractor gets the agreed levels of funding adjusted to reflect the effects of the changes.

The target level of funding delivered by retained purchase profits does not change – it remains £500m. Annual adjustments are made in fees and allowances. In 2005 purchase profit income was 28% of total funding. In 2009-10 it will be 22%.

How I would love to report to you that the CIP pricing problems have been sorted! But I can't.

Two years ago, when I met contractors, pricing accuracy was simply not an issue. Today it is. Contractor confidence in accurate pricing has disappeared. Rightly. Pricing and payment mechanisms are too complex for contractors, even using the systems offered by some PMR systems, to have accurate information about the payments due or to be able to easily check the payments. So accurate pricing is vital, and the NHS has a duty to provide it. It has failed in its duty.

We have worked hard with PPD (now called NHS Prescription Service but I will use PPD today), to identify and resolve problems: system problems and individual contractor problems. They have sought, and continue to seek, to identify where there may have been pricing errors. They have developed a programme to highlight accounts where there is likely to be a significant problem, and in the main they have made amendments to the programme promptly when an error has been identified. Many errors we pick up are human errors and we know PPD has engaged in a programme of retraining staff using CIP to address these. Generally PPD handling of calls from distraught contractors has been courteous. So much for the positives.

But they have also continued with a programme of extending use of CIP, closing pricing divisions and making redundant those very staff who had the skills to check for pricing problems. All pharmacies are now being priced with CIP. We are told that despite the errors, overall pricing accuracy is within target levels, and some pharmacies are being overpaid. Now if you own a number of pharmacies, a system of swings and roundabouts, where you get overpaid for some pharmacies and underpaid for others may be acceptable, if not ideal. But for a single independent this gamble is just not on.

Switching continues to be a big issue. Most switched prescriptions have not been properly endorsed, but not all. LPCs had feedback a few weeks ago from an audit of switching, showing that mistakes persist. And yes, contractors are required to ensure the declaration is completed. But the penalty for a mistake is unacceptably

high. The average prescription for includes more than two items – I think the figure is about 2.2. So the typical penalty for failure to ensure proper completion of the form is over £15.

I wrote to the Department of Health a few weeks ago to press for further action, and have had discussions since then. Lindsay has also been in regular contact with PPD. Some progress is being made. But not enough, and not quickly enough.

We continue to press DH and PPD for effective action. The Department of Health is actively involved, and is being very supportive in ensuring that the problems are resolved and restoration made. We are claiming compensation for all elements of cost to contractors. We will talk more about this when we come to the resolutions.

I have already highlighted some concerns most close to contractors' interests. But there are many others and these are three current consultations.

On Monday we submitted a response on the draft section 60 Order, which would extend the new regulators powers to enter and inspect pharmacy premises. We believe these powers would disproportionate and unbalanced, and that the increasing role of PCTs means that routine inspections are no longer needed.

Of course we recognize that the new regulator must have power to investigate complaints, and we hope to work constructively and collaboratively with the Department and the Society to find an effective framework for the regulators role. As community pharmacy becomes a provider with other providers of a range of NHS services, we believe the quality assurance regimes must be the same for all providers.

The government has appointed a panel to review prescription charges, and we have a resolution urging exemption. In January I was invited to give evidence at the first session of the review, chaired by Professor Sir Ian Gilmore, and as I prepared for this, it became clear to me how many of contractors' burdens would go with prescription charge exemption. Declarations; checking exemption status; switching issues. All go. For us it is a no-brainer. PSNC supports exemption. There are also massive costs in having an exemption system, not all of which are in the health budget, and the real net savings are well below the income.

The consultation on strengthening the medicines supply chain ends this week. Its objectives recognize the need to ensure that wholesale dealers are fit and proper persons to deal with medicines, and to seek to minimize risks of counterfeit medicines. We support these goals. Pharmacies must be able to rely on the supply chain to deliver them timely stocks, of reliable quality.

PSNC

The motions we have for debate today show the range of problems that we and you confront at present. I have tried to summarise for you briefly what the major issues are at present, and what we are doing. But we would not do our job properly if we confined ourselves to trying to address the current problems. Chris highlighted our priorities for the year. I do not have time to expand on these now.

We have limited resources, and in a time of financial constraint, although the scope and complexity of our work has expanded, we thought it vital to keep our levy increase to 3.5%. It means it will be a very tough year, but the contractors who represent their colleagues on the Committee thought it was right to limit the levy. We will find economies wherever we can.

We have 31 pharmacists on the Committee. 20 are independent pharmacy contractors. All our members reflect the concerns and experiences, the fears and the aspirations of contractors across the country. My team in Aylesbury are not out of touch. Through emails, calls and Committee meetings, as well as LPC meetings, training and other events, they keep well in touch.

We also try to keep you and all contractors informed, and provide the best possible news. Our website in January had 35,000 hits. Community Pharmacy News is, we know, read. We keep it brief so it will be read. And we publish supplements and guidance to help contractors have valuable reference guides. We offer training courses and seminars, publish LPC Upd@te. And this year we have launched our weekly electronic newsletter service.

You know what a committed team you have working for you at PSNC. Pharmacy's profile has risen immensely. And pharmacy has risen to the challenge. In 2008-9 when the figures are confirmed, I think they will show that pharmacies in England conducted 1.3 million MURs. That is a figure to be proud of.

The economic environment is grim; the weather has been pretty grim but it has improved. Funding for contractors in 2008 was grim, but it has improved. Community pharmacies are doing a great job for their patients, and between us – you the LPCs and we in PSNC – we have great opportunities to grasp as we implement the White Paper.

Thank you.