

## **Conference Report, Sue Sharpe**

Welcome to the LPC Conference and to Manchester.

We have a wide range of resolutions to debate today. They capture well many of the concerns and issues that affect our contractors, and I hope therefore that we will have a productive meeting.

Peter has summarised the changing face of NHS commissioning – the uncertainties and pressures affecting all parts of the NHS.

### **Community pharmacy**

Community pharmacy today is a part of the NHS. Not just from the increased dependence – total dependence for most, on NHS revenues. But also because the value of community pharmacy, and the value it could offer in the future, is understood. Not perfectly, but to a far greater degree than a few years ago.

Core to that value is dispensing and the procurement role that underpins it. Despite all the increased problems of sourcing supply, and the obstacles put in place by a growing number of manufacturers, pharmacies meet patients' needs, every day. That is recognised and appreciated.

When we had the flu panic, pharmacy stepped in to do its bit wherever it was allowed to do so. A few years before that, the oxygen fiasco. Community pharmacy stepped in. And we know these too were recognised and appreciated.

The White Paper – Equity + Excellence – Liberating the NHS published in July 2010, identified further roles for pharmacy in optimising the use of medicines and supporting better health. This is good. It is progress, and the NMS is tangible evidence of that progress.

So I want to begin by marking the progress we are making, and the success of the core service community pharmacies provide to the NHS. It is easy to lose sight of this as we focus on many difficult problems.

Moving to the tough stuff. It is and will be tough. For contractors, for us, for you.

### **COSI**

Money will be tight for years to come. Difficult questions will be asked, and every part of NHS spend will come under rigorous scrutiny. This will include community pharmacy, of course.

Last year Pricewaterhouse Coopers conducted the Cost of Service Inquiry. This was a far more extensive and complex undertaking than the 2003 Inquiry that underpinned negotiations for the 2005 contractual framework. The process took far longer than had been envisaged, and the report was only published in July this year, many months late. And it does not give a clear and simple answer. Far from it.

It is, of course, already out of date. It includes some costs that may be disputed; and some elements of the methodology will be questioned by one side or the other. We have real concerns about the ability of any inquiry of this kind to fully capture the costs of

independent pharmacy businesses. You will recall we expressed this fear at the start of the process.

So our negotiations with the Department of Health will take some time. Neither we nor they are bound in any way to adopt PwC's findings or recommendations. But this is not to dismiss the PwC report. It is the best evidence available, and our negotiations will be firmly based on it.

You will recall that the current contractual framework was based on the independent sector alone. The costs and NHS revenues of multiples – groups of 6+ pharmacies, were ignored. We currently measure purchase margin by looking at independents only.

In 2005 the independent sector held the majority of contracts. That has changed. And those of you who have read the PwC report will know that the costs of independent pharmacies, (we think they have been under-captured), are significantly lower than others.

We could not accept future funding based on the present, independent sector only. We need to reflect the current market. And of course the NHS will want to understand the costs and revenues – purchase margins - of the multiple sector as well as independents.

So we have long and complex negotiations ahead. People who are demanding a quick answer have got it wrong. The negotiations will set the basis for the next 5 years. With our duty to contractors, we must do all we can do to get a sound basis that supports them and their businesses. The negotiations leading to the 2005 framework were lengthy and painstaking, but although the contract is now in need of substantial reform, it has generally served us well. We have had year on year income growth, unlike others, including GPs.

A few weeks ago I spoke at the Pharmacy Show. For 67% of the audience, future funding was their greatest concern. We will work, as will the Department of Health, as quickly as we responsibly can. There will be no dragging of feet. And I believe we will be able to do a lot, maybe even finalise the negotiations, by the time next year's funding is settled.

## **Funding 2011-12**

The funding settlement for this year attracted some criticism - inevitably. But I want today to invite you to look at the significance of that settlement. As you know the background was no increase in public sector pay.

We made our case strongly and persistently. After prolonged negotiations, funding was agreed that included concessions amounting to £80m benefit. £20m owing from last year was written off; a deferral of margin adjustment of £40m for the remainder of the year was agreed, and we secured £20m in acknowledgement of the CIP pricing problems. This means contractor funding allowed for this year is more than 3% higher than government pay freeze policy would indicate. Add the £55m for the NMS and there is 5.5% additional funding provided in total.

In addition, we identified that prescription volume increases are slowing, and at a level below government volume forecasts. So we persuaded the Department of Health that an increase in Practice Payment was needed to prevent an under-delivery of the

£2.526bn for the current year. An additional 3.2p per item was added from October, and as a result of more detailed analysis, a further 3.6p per item will be added from December.

Mike Dent pursued this like a terrier onto a rabbit. It all helps.

### **Market Entry**

The market is still growing, and very many long-established pharmacies have come under pressure from new entrants, predominantly those using the 100 hour exemption.

We have spoken before of the unintended consequences of the 4 exemptions introduced by the last government in 2005. The so-called balanced package of measures, remember? Well they have added at least 14% of new pharmacies to date. And they have to be paid for somehow.

Of course competition is a good thing, and can be used to drive up service quality. But it can also operate to do the opposite when underfunding means costs must be cut. For community pharmacy, at a time when the NHS can achieve so much from effective use of our skills and resources, dilution of funding caused by increased pharmacy numbers is pernicious.

At long last the recommendations of the Advisory Group have been published. Those recommendations owe much to the work of Steve Lutener and Gary Warner on the group, and thanks are due to both of them. However it should be said that there was widespread support for the core proposals around the table – from NHS Employers and PCTs, and from Dispensing Doctors. We hope and expect that the exemptions, bar the internet/ mail order one, will be removed shortly after the consultation period closes, at the end of January. Before then we can expect more openings as people rush to get in before the shutters come down. No, we could not persuade government to introduce a moratorium. Yes we tried, many times. Yes they too were concerned at the increase in pharmacy numbers, but they could not do it.

PSNC will agree its response to the consultation in January, but Steve will circulate LPCs with a paper on some of the key issues within the next week or so, and hopefully a draft of the PSNC response before Christmas. Mike King has planned LPC training events to take place after the regulations have been finalised, so that you will be proficient in dealing with the new market entry legislation.

### **Pricing Accuracy**

More tough stuff. You know of our work to identify and deal with the inaccuracies of pricing caused by introduction of the CIP system in the NHS BSA, a system that was and is not fit for purpose. For several years in my report to you I have spoken of our work – our audits of prescriptions, identifying pricing problems and ensuring that errors are rectified, for individuals and in the systems.

We have been able to ensure that a lot of problems have been addressed, and our persistent pressure – on the Department of Health and in our work with the BSA – has made a big difference. What it cannot do is make a system that is not fit for purpose become fit.

But I want to emphasise the importance of our work in identifying the faults in pricing by the BSA. Without us – the team at Enfield – many important pricing errors would not have been identified, and many rectifying amendments would not have been made.

For many years, the resource we put into prescription pricing audit was taken for granted. The problems of recent years – switching, missing forms, pricing errors, have pushed it into the limelight. We have invested a great deal of our funds into a new system that will support our pricing audit work and increase our capacity to undertake pricing accuracy checks, and in future to allow us to scan across all payment schedules for likely problems. The PRISM project has been and is very resource intensive, but is beginning now to be deployed, although there is still much work to be done. It is a remarkable tool.

There is a solution. Many but not all of the CIP problems are caused by the need for the system to try to read and interpret prescriptions. That job has already been done in the pharmacy, and the message captured electronically in the PMR system. The solution is to use PMR data to produce an invoice for the NHS. Our work on the PRISM pricing engine has proved that we can recreate (and improve to deliver accurate pricing) what happens at the BSA.

We commissioned an expert report on this solution for the Department of Health, and will press for adoption of a system based on this approach – that is something that is fit for the future. There is no confidence in the BSA. There is, in my view, no prospect that it could be restored. And the only conceivable justification for the current system is history. I doubt that there is any other part of the public sector that is expected to suffer such a disgraceful process for reimbursement and payment..

## **Shortages**

Effort in sourcing hard-to-get products is, sadly, now the norm for pharmacies. Yes there is the risk of exporting – inevitable in a single European market with prices varying considerably. But the obstructions to getting medicines that some branded manufacturers have put in place is appalling, and unjustified by that risk. From time to time we have had a war of words, where they denounce community pharmacy as exporters in response to our demands to be able to meet our patients' needs.

We continue to try to get government to intervene effectively to address the problem caused by the manufacturers' actions, which is adding many millions of cost to the NHS. We worked to get agreement on best practice across the supply chain. This was published but ignored by the manufacturers who needed to respond to it! Then the Secretary of State responded to a PQ, suggesting – I suspect unintentionally – that the problems have been resolved. I have written to him – together with the CEO of the wholesalers' organisation.

The All Party Pharmacy Group has just launched an inquiry into shortages. This is welcome and will help us keep it in the spotlight.

Before I leave this, I want to highlight a little bit of Direct Action. Last month Sunderland LPC wrote to the MD of the manufacturer of Spiriva about inadequate quotas imposed on pharmacies in an area that, largely because of its industrial history, has COPD levels way higher than the norm. They copied it to Lord Howe, the minister. The manufacturer

responded speedily, promising a meeting with one of their directors. Quotas seem to have been adjusted almost immediately. Good work by the LPC. Well done Kathryn.

Our Yahoo Group for LPCs encourages some excellent sharing of resources, experiences and ideas. There are many – I think a growing number of regular contributors. Keep going – it is good.

### **Contract changes**

Time to focus on positive developments. The two principal contract changes introduced in October are really important.

Targeted MURs first. For 6 years we have had a very light touch regime for the MURs. Capped at 400 per pharmacy, there has been no mandatory prioritisation of patient groups and my impression is that few PCTs identify target areas for their pharmacies. If in the future MURs are to become a part of established patient care pathways, I believe they may need to be restructured so that all patients with a specific condition will receive the intervention. But before we get to that stage, some balance between giving pharmacists discretion to identify those individual patients who can benefit from the service, and targeting the disease areas that are most likely to be rewarding, is a welcome development.

In our negotiations with NHS Employers, they share our wish to ensure that MURs are more effectively targeted, and of course, we need to prove the outcomes of the service if we want to see it continue and expand. More on this in just a moment.

It is hard to overstate the significance of the NMS service to pharmacy, or Alastair's role in bringing it about. Where else in the NHS, with the massive cuts being demanded, is a new service being commissioned and funded? You heard Peter's view.

The NHS is really positive about the NMS. It is based on sound evidence that interventions in the early days after the first prescription can improve adherence. We have a once-in-a-lifetime opportunity to prove that community pharmacy can take up this role and deliver outcomes that offer real benefit to patients and the NHS.

That is why we deployed so much effort to making sure we got the service up and running from October. Delay to next April would have meant, not only that we lost £55m of funding, but also that we lost our opportunity to prove the outcomes before the NHS Commissioning Board takes over responsibility for service commissioning.

It is a great service. Early providers and patients have been very positive. There are a range of teething troubles that we are working to sort. But initial adoption levels have been excellent.

So thank you for all you have done to make this happen. I know many of you have been very active in arranging training, and in encouraging contractors to get going on the service. Both you and we are here to work for contractors, not for ourselves. And many of you have been doing a great job on the NMS.

### **Pharmabase**

We need to prove the value of our interventions. Whether they are MURs or NMS – or indeed any other services – medicines optimisation, public health-related, minor

ailments. It is not easy, and we have spoken on many occasions about the complexity, time and cost of recording pharmacy service provision.

Did you know that pharmacies in England have undertaken over 8 million MURs? You do now! Do you know how many of them were respiratory MURs, and in how many of those problems with inhaler use were identified? No, nor do I. Nor does anyone. The data is sitting in PMR systems, or worse, on paper in pharmacies where it is, frankly, useless.

The MURs on which the reputation of the service rests in the NHS are often those rubbish records that the GP proffers to the PCT. That is bad, and a big risk. We cannot afford not to tackle it.

So the Pharmabase NMS service will provide a databank that will collect data, and allow us to demonstrate what has been done, for what patients, with what results. It is vital that we do this. Thanks to the immense efforts of my team, in particular Alastair and Gary Feary, Pharmabase was able to support NMS delivery from day 1. It too has teething troubles – what IT system does not? But I would say that if Gary and Alastair had been in charge of implementing EPS, it would be a reality today! Perhaps good that they were not, then!

At present, some contractors whose PMR supplier has developed an NMS recording module, are not using Pharmabase, and of course it is their decision which system to use. We are in discussion with the PMR suppliers, to ensure that the records in their systems can feed into the databank. We hope contractors and system suppliers will understand the need for this and ensure that their service data supports our arguments to continue and develop the service.

Pharmabase, and particularly the data storage, costs a lot of money. We have developed it as a co-operative venture. The shares in HIE Ltd, which owns Pharmabase, are wholly owned by PSNC. All revenues will be used to fund Pharmabase and reduce levies on contractors. So it is in effect owned by all pharmacy contractors and operated for their benefit.

We decided to fund Pharmabase, after our initial investment, via the hypothecated levy because it is there for the use and benefit of all contractors, both use of the modules, and central collection of that vital data. We still believe that is right, and it allows the cost to be significantly lower for contractors.

Last year we asked for a levy equating to £75 for the average contractor. I told you the levy this year would be considerably less. We hope to ensure that it is below £60; PSNC will scrutinise the HIE Ltd budget in January before making a decision. I do not need to remind you that PSNC comprises contractors who will pay the levies. So they will ensure we collect only what we need

Of course any contractor who begins to provide the NMS service this year does not only have the opportunity to gain payment for the service; he can also claim the start-up payment of £750.

In addition to the New Medicine Service, Pharmabase supports and will facilitate recording and claiming for an increased number of locally commissioned services. Focussing on getting the NMS module sorted has meant that some of the other modules to support enhanced service commissioning, and our work with you and PCTs, have had

to take second place. We are getting back on track now, but I know this has been a frustration for some of you.

I do not have time to discuss this further today, but I believe PharmaBase will be used increasingly by new commissioners in future, and we will work with you to develop those opportunities. There is also significant interest in the contract workbook module, and work is underway to update this from 1 April, when the new clinical governance requirements come into force.

PSNC has agreed to support Pharmabase until 2013, the period for which at present we have funding for the NMS. Of course, if contractors have failed to deliver the service to scale and quality, and it is not continued, we will have to look at its costs and value for the future. I am an optimist, but I think I am a realistic optimist. My request to you is – stick with it, support it. We need data.

### **Government policy on pharmacy**

We have government support for pharmacy as a service provider. The White Paper Equity and Excellence makes this clear. And look at what Lord Howe said at the BPC in September.

Integration is a must-do, as you can see from his quote. Effective communication is key to developing our medicines optimisation role, and will be a big challenge for contractors and LPCs. It is easy to pin blame for lack of communication and partnership working on GPs. But that does nothing to resolve the issue, and it is not the whole story. And if we need integration, then we and you need to work on it.

Public health is another big area, particularly with this government's decision to establish Public Health England with a dedicated Budget. Barbara plays a lead role in pharmacy public health service development, including the Healthy Living Pharmacy pilots, promoting flu vaccinations and other services that you work on locally. Our services database is a good resource; please do use it.

### **LPC structures**

Which brings me neatly on to you. There is some excellent work going on. When my team visit LPCs we see some great examples and initiatives of good, effective local representation.

In recent months we have been working to support you in reviewing your structures to ensure they are the best for the future challenges. Some of you have made changes – either by merging, or federating or sharing resources. This is really good, and the work needs to continue.

Assuming that the NHS Bill passes into law in more or less its current form, you will need to operate to represent contractors at a number of different levels.

The NHS Commissioning Board will take on many of the functions of PCTs, including market entry. It will, at present, have 4 regions and, as at last week, around 50 local offices. They plan to introduce Local Professional Networks, and Steve has been briefing you on those. You will need to ensure that the contractors you serve have an effective voice with them. It will not be the only voice, but it must be strong and influential.

Local Authorities will probably be responsible for maintaining PNAs, as well as commissioning public health services locally. As the Health and Wellbeing Boards get going you must ensure that the opportunities for pharmacy services are compellingly presented, and lead to service commissioning. Some of you have already heard me speak of the opportunity to use this relationship with local authorities to promote commissioning of social care services from pharmacies. It is a golden opportunity. You need to be putting the case to Local Authorities persuasively.

Clinical Commissioning Groups will be the most local bodies. You will need to work with them to achieve that integration and partnership working the minister identified as essential. They will be commissioning from local providers, and have significant control of prescribing policies – highly relevant to our contractors - as well as specific clinical service provision. They will want to be talking to local pharmacies, with whom they operate, and we must have structures that ensure the right people talk to them.

I do not think there is a one size fits all solution to how best to work at all these levels. But equally, it is unlikely that old arrangements are likely to be the best for this new world. At the very least they need critical examination.

## **PSNC**

That is you. Well what about us?

Our budget for the current year is £3.294m, of which we aim to provide £175,000 through the Partnership programme.

We have been through a restructuring exercise. In the last year we have undertaken a zero based budgeting programme, to examine rigorously and critically all areas of our activity and spend, to ensure our use of contractors' funds is delivering the best value possible.

We also had some significant staff changes. Lindsay McClure, our IT guru, our Drug Tariff maestro, decided after 10 years with PSNC to undertake a masters degree in London. She is still working for us on IT as a consultant. Lindsay did an amazing job – her commitment, hard work, persistence were always exemplary. Way beyond expectations.

Janet Edginton headed up the pricing audit work, and has overseen the PRISM pricing project about which I spoke earlier. Like Lindsay her dedication, hard work and effectiveness were tremendous and we were sad to lose her. Janet is also continuing to help us finalise PRISM for now.

The zero based budget exercise led to some major changes. They include some restructuring of our staffing, and I want to welcome Komal Patel who is here today, our new Head of Support Services. Komal will head up our Information, research, administration and support resources so we can make the most effective and economical use of our support staff. We have some excellent people in the Team – you will rarely hear of them but they are essential to allowing our policy team members – those you know – to use their time most effectively.

We also made the decision to leave our Aylesbury home and relocate to London. The demand on us of meetings in London – with the Department of Health, NHS Employers,

and of course in future with the Commissioning Board – has meant that Aylesbury as a location was no longer fit for purpose. We will function far more effectively as a team by locating in London.

So we will say goodbye to our Administration team – my PA Marion, and Jane Reynard, who many of you will know, as well as one of our support team workers, Helen, who will not relocate with us.

### **PSNC Expenditure**

As part of our ZBB process we allocated expenditure to a number of heads. This slide collates those, and gives an indication of how we spend the levies. You can see here the principal areas of our work highlighted: each area is essential if we are to do our job for you and for contractors.

Of course we need to ensure that we can manage this without seeking a large levy increase, and through the restructuring, we will be able to do so. We need to invest in our pricing audit work. We must continue creating support for the future pharmacy service and developing evidence, securing fair funding, monitoring margins, ensuring reimbursement is fair to all. And supporting you and your work.

I have a brilliant team to do all this, and I want to thank them, in particular this year and going forward, for their support for me

### **Looking Forward**

The resolutions we have to debate today give a good reflection of the issues and challenges that our contractors are facing. As community pharmacy has moved into the mainstream – and it has moved a long way – we need to embrace constant change and constant challenges.

The introduction of the Community Pharmacy Contractual Framework in 2005 was driven by two major factors. The first was the government's demand for transparency of pharmacy funding including procurement income and margins. The second was the shared ambition to develop the national service provided by community pharmacy from one focussed almost exclusively on procurement and supply, to extend into patient care and promotion of good health.

Funding today is still directed principally towards the supply function. Our service goals for the national contract, confirmed at our Planning Meeting two weeks ago, are Medicines Optimisation, Public Health and Minor Ailments. In this period of transition in the national NHS structures, as Peter said, we cannot expect any fundamental change to the contractual framework. It must inevitably await the Commissioning Board taking over responsibility in 2013. But we will, I believe, be negotiating some changes in funding delivery next year, moving towards identifying and directing more funding towards provision of non-dispensing services.

More importantly, we will need to be sure that we have the influence at national level to ensure that the NHS Commissioning Board understands how it should use pharmacies and is committed to doing so. And also to ensure that the national structures support you in your work.

And last but absolutely not least, to have the funding needed to reward and incentivise pharmacies to invest so they can provide the services that offer great value to the NHS.

I am closing there to move on to questions. Thank you for listening.