PSNC Minutes

For the meeting held on 15th May 2013

At the Old England Hotel, Bowness on Windermere, Cumbria, LA23 3DF

Present: Stephen Banks, Dhiren Bhatt, Christine Burbage, Mark Burdon, Peter Cattee, Liz Colling, Ian Cowan, Ian Cubbin, David Evans, John Evans, Mark Griffiths, Kirstie Hepburn, Elisabeth Hopkins, Tricia Kennerley, Andrew Lane, Fin McCaul, Rajesh Morjaria, Garry Myers, Bharat Patel, Indrajit Patel, Kirit Patel, Rajesh Patel, Umesh Patel, Janice Perkins, Alan Robinson, Gary Warner

In the Chair: Sir Peter Dixon

In Attendance: Alastair Buxton, Harpreet Chana, Mike Dent, Mike King, Steve Lutener, Barbara Parsons, Komal Patel, Sue Sharpe, Zoe Smeaton

1. Apologies for absence

Apologies were received from Mark Collins (Fin McCaul deputised), Andy Murdock, Omar Shakoor, Chris Perrington and Adrian Price.

2. Training needs

The information in the agenda was noted.

3. Minutes of the last meeting of PSNC

The minutes of the PSNC meeting held on Wednesday 13th March 2013 were approved.

4. Matters arising from the minutes

The Committee's procedures and practice on deputies attending meetings will be considered by RAP.

5. Chairman's report

The Chairman noted the turmoil which had been occurring within the healthcare environment, including budgetary shifts being made for specialised services from CCGs to NHS England. Senior leaders in healthcare seemed to view the changes unfavourably and improvement in the situation was expected to be slow. The challenge of lengthening A&E waiting times was currently a focus for most commissioners; this may create opportunities for pharmacy in due course.

Chief Executive's report

Funding negotiations

It is immensely frustrating that, almost 3 years after the publication of the COSI report we still have no offer. I forecast this risk in July 2012: that as we moved closer to the transfer of responsibility, the impetus for DH to conclude negotiations would have to diminish, and it would become necessary to involve what is now NHS England. For contractors, the lack of certainty inevitably causes concern and lack of confidence, although in practice the lack of a CoSI based settlement for 2012-13 is not bad, given NHS policy of no additional funding for any sector, with 4% efficiency demands, coupled with early intelligence about retained margin levels. Timescales for conclusion of negotiations are very uncertain, but PSNC needs to ensure it has proper

opportunities to consider and reflect as negotiations progress, and in practice this means there will be several more months before a conclusion is possible.
The uncertainty for contractors is compounded by the problems they are facing with generic shortages and price rises. These highlight the inability of current mechanisms to cope with the problems we are now seeing in the market, and FunCon considered a possible amendment to the NCSO/concessions systems, which may be better than the current arrangements.

Conference
Feedback was good; felt to be a worthwhile and helpful event. Delegates heard from new key contacts – Deborah Jaines and Clare Howard, as well as Jeannette Howe. Unusually it focussed on NHS structures rather than services although the session highlighting Manchester's innovative commissioner engagement event has already sparked a number of similar events. Attendees included commissioners – a number of Directors of Public Health.

Feedback was good not only from delegates but also from the exhibitors. So a good and worthwhile day and thanks to all involved.

GPhC Case
The GPhC Fitness to Practice Committee has ordered that a pharmacy contractor be struck off the register for producing false prescriptions in order to get medicines from GSK, supplies of which were being managed. There were 92 forged prescriptions and two medicines involved, Tyverb and Votrient, both of which were several hundreds of pounds more expensive in Austria/ Germany than here. The decision was based on the finding that the contractor had, by his forgery and dishonesty in initially lying about his actions, demonstrated that his integrity could not be relied on.

PSNC Market Entry Masterclasses
PSNC organised two Market Entry Masterclasses, but doubled this to four, and increased the capacity to 50 at each due to high levels of demand. The first was held on Tuesday 30 April in Leeds. The day included detailed updates on the changes to the regulations, reflecting the revised market entry test, as well as several sessions in which delegates examined applications, alongside a PNA and the regulations. By the end of the day, delegates were able to identify and apply the regulations that are relevant to the applications on which LPCs will be consulted. Feedback forms are always used for PSNC events, and these again recorded excellent appreciation. The only negative comment was the food at lunchtime could have been hotter.

Funding Webinar
Mike Dent held a funding Webinar for LPCs and contractors in and around the North East on May 2nd. Attendance, feedback has been very good, and the word passion has been used to describe it!

A+E services
I wrote to Dame Barbara Hakin last week, following her request to Area Teams to tackle waiting times in A+E to press for use of pharmacies to reduce demand. We have also alerted LPCs to the need to use this to approach ATs.

Key work areas
The transfer of responsibilities to NHS England has led, not to a stop on funding discussions, but Mike has been working with DH on finalising update work, and identifying key objectives, as

discussed in the group discussion session. It is too early at present to predict when negotiations will get going, or indeed how and with what cast list, and what timescale. We have emphasised strongly the need to ensure that PSNC has proper time to consider, reflect and respond to proposals.

Shortages work + issues
This has been a massive issue for the Info Team, Harpreet and Komal. Komal's team have been able to gain far more knowledge about what was happening than we have had previously, and this allowed us to identify the shenanigans of a limited number of suppliers. The PRISM system has produced good data on the operation of the current system, which will be published.

LPC Survey summary
Mike King has led this and the results were presented and discussed in the LIS Group discussion yesterday. The survey shows the wide range of support we provide, and also how well it is valued. LIS will ensure we build on this and the feedback comments.

Website refresh. This was presented to LIS; it has been a complex project and particular thanks to Zoe and Komal for leading the work. We have moved from Fat Beehive to Jellyhaus; there was a small problem last week with some pharmacies experiencing temporary problems accessing our website. We will be using the new look to review our LPC and contractor comms presentation.

Visit to CPF sites
The CPF project has now been rolled out to a number of non 4 large multiple pharmacies. Alastair and I visited for pharmacies, together with NHS Employers' representatives. The enthusiasm of the pharmacists and teams, and the good patient feedback, was impressive. The evaluation will establish the health economic case for the services. A meeting to review early progress was held at DH last week.

Stephen Pound MP held an adjournment debate in the House of Commons. This was an RPS initiative but Zoe provided briefing (a good example of productive collaboration), and Stephen contacted her to say he was persuaded by the 3rd Pillar proposal. He made an excellent speech, highlighting two local pharmacies' services. Norman Lamb responded, but this was entirely non-committal.

Lindsay McClure has just taken up an exciting procurement job in Scotland. Her responsibilities for EPS have been taken on by Daniel Ah-Thion, with Komal's management.

HLP Launch
Barbara has worked very closely; discussions on next steps will continue. The report has some positive messages, but the lack of a robust and standardised evaluation framework has been a very visible problem. We will be working with the other pharmacy organisations to consider if there is a case for an independent system for badging HLPs.

LPC Secretaries + Chairs Looking forward we have the LPC Secretaries + Chairs conference next month, and a number of topics to discuss, including the survey, preparation for elections, the websites, and engaging with new commissioners.

Elisabeth Hopkins commented on the historic positivity towards pharmacy of Stephen Pound MP.

Update on the Healthcare Landscape

NHS England

Since PSNC last met the 1st April has come and gone and the NHS Commissioning Board became fully operational and re-branded itself as NHS England. It also determined its goal to be 'high quality care for all, now and for future generations'.

Challenges

Inevitably the creation of such a significant new NHS leadership organisation has not happened without a few challenges along the way:

- A Board paper revealed that at the time the organisation took on its full powers, one in ten posts were unfilled (89% of posts filled at 31st March, representing 6017 of a total of 6736 posts). 58% of employees were transferred directly from predecessor organisations by 'lift and shift' or by a job matching process; 31% were appointed by 'ring fenced recruitment/redeployment' from predecessor organisations and the remaining 11% were appointed by external recruitment.
- HSJ has reported that the internal IT system being set up by Atos will not be fully functioning for up to six months after April.

Plans for 'ambitious and radical' service change

In an interview with HSJ, Bill McCarthy, Policy Director said NHS England was drawing up plans for a programme to focus on large-scale service reconfiguration, rather than on smaller incremental savings schemes. This work, led by its Area Teams, would continue the QIPP drive beyond the current programme endpoint of 2015.

Bill McCarthy said the bleak outlook for public finances beyond 2015, and the fact that the NHS was already relatively efficient by international standards, would force the service "into the direction of strategic change". He said "year after year whittling away of unit cost" did not "seem to me to be an answer to the challenges we're facing".

NHS England's 27 local area teams would drive reconfigurations, working within a national framework developed by the organisation. This could include leading public consultation processes and coordinating input from CCGs.

Business Plan

Later in April NHS England published Putting Patients First: The NHS England Business Plan for 2013/14 – 2015/16 which sets out how it will improve quality and secure the best possible outcomes for patients and best value for taxpayers. Responding to the Francis report is at centre of the business plan, requiring a fundamental cultural change in order to put patients at the centre of the NHS.

An eleven point scorecard will be introduced for the organisation's priorities in order to improve transparency. Two elements of the scorecard – direct feedback from patients and their families and feedback from NHS staff - will be more important than the others.

Priority		Scorecard measurement
1	**Satisfied patients**	Net score of positive versus negative feedback (scale -100/+100)
2	**Motivated, positive NHS staff**	Net score of positive versus negative feedback (scale -100/+100)

3	Preventing people from dying prematurely: Outcomes Framework Domain 1	Progress against Improvement areas 1.1 – 1.7
4	Enhancing quality of life for people with long term conditions: Outcomes Framework Domain 2	Progress against Improvement areas 2.1-2.6
5	Helping people to recover from episodes of ill health or following injury: Outcomes Framework Domain 3	Progress against Improvement areas 3.1 – 3.6
6	Ensuring people have a positive experience of care: Outcomes Framework Domain 4	Progress against Improvement areas 4.1 – 4.9
7	Treating and caring for people in a safe environment; and protecting them from avoidable harm: Outcomes Framework Domain 5	Progress against Improvement areas 5.1 – 5.6
8	Promoting equality and reducing inequalities in health outcomes	Progress in reducing identified health inequalities on all indicators for which data are available
9	NHS Constitution rights and pledges, including delivery of key service standards	The proportion of people for whom NHS England meets NHS Constitution standards
10	Becoming an excellent organisation	Staff survey results, 360 degree feedback
11	High quality financial management	Actual spend versus budget

NHS England aim to achieve the outcomes by using the eight components of their operating model to ensure that the commissioning system is working to maximal effect:

a) Supporting, developing and assuring the commissioning system;
b) Direct commissioning of specialist services, primary care, public health services, dental services, armed forces health services and offender health services;
c) Emergency Preparedness;
d) Partnership for quality;
e) Strategy, research and innovation for outcomes and growth;
f) Clinical and professional leadership;
g) World class customer service: information, transparency and participation;
h) Developing commissioning support.

The business plan also describes NHS England's values:

> We are committed to achieving better outcomes for all in the right way:
> **We put people first**. Everything we do is directly connected to our purpose of improving outcomes – not a process, not an organisation, not a profession – but the person who needs the NHS to care for them.
> **We make informed decisions**. We listen to the people and communities we serve, we look at the insight and evidence and we measure our outcomes, so that our decisions are objective and we understand their impact.
> **We are open and transparent**. We are accountable and we take individual and collective responsibility for our actions. We act with integrity and we are transparent

about the decisions we make, the way we operate and the impact we have.
We are inclusive. We work in partnership with patients and clinicians, the public and our partners because we get the very best outcomes when we work together with common purpose.
We are relentless for improvement. We believe we can always do better for patients and will challenge and seek challenge. We share ideas and knowledge and take risks because we believe in innovation and learn from our mistakes.
We listen and learn. We believe everybody has the right to a good idea and to be listened to carefully and thoughtfully. We respect and support each other, building trust to encourage everyone to give their very best.

The plan contains the following specific references to primary care services:

As a single commissioner of primary care services, we have the unique opportunity to redefine the role of primary care in an effective healthcare system and to take steps to address inequalities of access to primary care services, whilst improving the quality of care and outcomes for patients across the country. We aim to do this by:

- Developing and reviewing contract levers to ensure that maximum benefits are achieved through rewarding quality services and better outcomes for patients;
- Managing the smooth transition from PCT commissioning to area teams. The single operating model we will develop will include developing a single approach for effective performance management of primary care;
- Improving the skills of practitioners in primary care through the development of robust workforce planning ;
- Developing and maintaining mechanisms to enable revalidation of GPs, ensuring that skills are up to date and clinical standards remain high.

We will establish a Primary Care Patient Safety Board and develop a comprehensive primary care patient safety strategy that will feed into the overall primary care strategy.

Some patients find it more convenient to access GP services away from home. We will evaluate the results of the GP choice pilots and consider how we can apply successes more widely. We will move towards a more equitable system of GP practice funding to support patient choice. We will continue to support and incentivise practices to offer greater access to services through digital means.

The document commits NHS England to develop a ten year strategy for the NHS which will align with the five domains for the NHS Outcomes Framework. The strategy will consider and address unmet needs and inequalities in outcomes and access to services, commit the NHS to a fairer deal for all, and confirm patient rights outlined in the NHS Constitution. It will also focus on the commissioning system itself. This will cover cohesive development and support for clinical commissioning, future direction for commissioning support services and the development of high-impact levers and tools.

It also says NHS England will focus on the development of primary care in the light of changing populations and medical models of delivery. NHS England will consider what practical changes, data, market management, workforce development and contract mechanisms will deliver continuous improvement.

Standard policies

NHS England has published a large number of internal policies which form part of its single operating framework. Some of the policies apply to its direct commissioning activities, including primary care. One policy of note is on in-year service developments:

> A service development is any aspect of healthcare which NHS England has not historic agreed to fund and which will require additional and predictable recurrent funding. The t refers to all decisions which have the consequence of committing NHS England to r expenditure for a cohort of patients including: new services; quality improvements; requ to alter an existing policy and pump priming to establish new models of care.
>
> It is normal to consider funding new developments during the annual commissioning rou An in-year service development is any aspect of healthcare which NHS England agree fund outside the annual commissioning round.
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> Applications for service developments will generally only be considered and prioriti during NHS England's process for developing its Annual Commissioning Plan. The Ann Commissioning Plan defines the commissioning position for NHS England for each finan year. NHS funded healthcare will only be commissioned by NHS England in accordance v the Annual Commissioning Plan.
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> When NHS England considers funding a service development outside the nor commissioning process, it is vital that the opportunity cost for NHS England to fund ot areas of competing health needs is taken into account. Unplanned investment decisi should only be made where they have been approved in accordance with the terms of policy. Usually this will be in exceptional circumstances because, unless they can be fun through
> disinvestment, they will have to be funded as a result of either delaying or aborting ot planned developments.
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> A consequence of this approach is that NHS England's default interim policy will be no fund a proposed service development.

Review of primary care

In a speech given to an Age UK conference in late April, the Health Secretary, Jeremy Hunt, announced an initiative to 'rethink the role of primary care'. He highlighted the rise of long term conditions and the challenge this presented with resultant increases in A&E attendances. A&E staff cited the lack of beds to admit people, poor out of hours GP services, inaccessible primary care and a lack of coordination across the health and social care system as the basis for the current challenge. He said "the decline in the quality of out of hours care followed the last government's disastrous changes to the GP contract, since when we now have 4 million more people using A&E a year compared to 2004".

Jeremy Hunt set out four areas that need to be addressed if the health and social care system is to manage the challenge of long term conditions effectively:

1. Treat the person not the condition – a focus on integrated services;

2. The role of primary care – the need to rethink the role of primary care, in particular its ability to prevent the need for emergency admissions.
    - Sir Bruce Keogh's review of emergency care will report in May and will cover the issue of demand for services and what needs to happen to make sure people with long term conditions are better looked after outside the hospital system;
    - Norman Lamb will be announcing plans for local pioneer sites to lead the way on developing better care outside the hospital system;
    - NHS England has been asked to look at the system-wide operational incentives that need to change to make this happen.
3. Care and treatment – following in the wake of the Francis Inquiry report, the Secretary of State said we need an NHS and social care system where care is just as important as treatment.
4. Better care and diagnosis of dementia - NHS England will shortly be announcing its new ambition for national dementia diagnosis rates alongside proper care plans for all those diagnosed.

The speech coincided with DH asking NHS England to review out-of-hours care. NHS England's deputy medical director Dr Steve Field commented that GPs should "never have given up the responsibility for out of hours care", but Dr Mark Porter, BMA chair, said: "The Government's analysis of where responsibility lies for the huge and increasing pressure on emergency care is completely simplistic. Singling out individual parts of the health service and engaging in a blame game is unhelpful and misses the point". The BMA has written to the Secretary of State asking for an urgent meeting to discuss the matter.

Speaking at the Pulse Live conference, Professor Malcolm Grant, chair of NHS England, said the three 'big things' that the organisation would focus on this year would include how to incentivise 'medium term' outcomes in primary care. The other two priorities will be addressing the rising pressure on A&E departments and mortality rates at certain hospitals.

Professor Grant said that he was not in favour of redrawing the contract for GPs to take back out-of-hours care, in order to address the rising pressure on A&E departments, but that there did need to be a 'joined up idea' of the source of the problem. He said "I am not really keen about the GP contract going through a battle every year, without a clear vision of where it is going". When asked if this meant there was going to be a fundamental review of the GP contract this year he agreed, saying "It will be put out to consultation later this year". He said that NHS England intended to ensure that the GP contract struck the 'right balance' between providing resources for an elderly population and supporting practices in deprived areas.

In a recent Guardian interview with NHS England Medical Director, Sir Bruce Keogh, he said NHS England was considering whether "differential payments could be used to tackle variation in the quality of care provided by GPs". NHS England confirmed that they were reviewing QOF and all other sources of practice income as part of the review, to support the achievement of NICE-defined outcomes. The review will look at 'the full spectrum' of GP pay in England over the next couple of years, including which areas of practice funding should become subject to more performance measures.

It comes after DH accepted Monitor's proposal, set out in its Fair Playing Field review, to undertake more work on commissioning of GP services. Monitor's report says questions were

raised during the course of the Review about the extent to which the commissioning of general practice and associated services in particular is operating in the best interest of patients.

Issues raised included:

- the rules for setting up a general practice;
- the different contractual terms under which practices operate;
- the perceived reluctance of PCTs to commission new services against the wishes of existing local practices and Local Medical Committees;
- perceived conflicts of interest that may in future prevent clinical commissioning groups from commissioning services from new entrants; and
- concerns about a lack of choice of general practitioners for patients.

The report proposed that 'Monitor should issue a call for evidence by June 2013 to help determine the extent to which the commissioning and provision of general practice and associated services is operating in the best interests of patients'.

Commissioning Support Units

It has been reported that independent sector companies will be encouraged to work in partnership with the 19 NHS CSUs, rather than competing for business from commissioners. A draft NHS England report apparently proposes that CSUs should be able to enter into contracts of up to 5 years duration with commissioners such as CCGs; it is hoped this will stabilise the commissioner support market and allow CSUs to agree partnerships with commercial providers. The final guidance is expected to be published by June.

At the end of April it was reported that Surrey and Sussex CSU has been deemed to be unviable. NHS England is considering options for its future with local stakeholders; one option may be merger with another CSU.

Competition and Choice

A summary of the current policy position on competition and choice is set out in the May SDS agenda. Due to ongoing lobbying by interested parties and unrest in parliament about the provisions of the Health and Social Care Act this continues to be a fast moving area of policy.

In a recent HSJ interview with David Bennett, chief executive of Monitor, he rejected claims that the new competition regulations could lead to a sharp increase in competitive tendering for NHS services. He said "Fortunately for the patients of England, we have a duty to do whatever we do with a focus on what's in their best interests. We would be mad to enforce those rules in a way that leaves commissioners spending all their time running competitive processes because they're terrified they're going to get into trouble if they don't".

Mr Bennett noted that there were 211 CCGs, each with an estimated 60 to 600 contracts, while Monitor would have only around 40 employees investigating competition issues. "We're going to have to prioritise and we're going to be extremely clear about how we will prioritise what we do. We will be focusing on areas where we think opportunities to improve the service delivered to patients have been missed in a serious way".

David Bennett and Catherine Davies (Monitor Cooperation and Competition director) told HSJ competition regulation would be largely "complaints driven", and its assessment of complaints would hinge on whether the commissioner had acted in a reasonable way. They

suggested this would begin by looking at the commissioning plan the CCG had developed with its HWB.

Monitor's steps would be to ask, have they gone through a process? Have they established a commissioning plan that sets out what they want to do? Is the conclusion they've reached a reasonable conclusion given the steps they've followed?

Mr Bennett also indicated that in some cases it might be reasonable for commissioners not to run a competitive process for a service, because they did not feel they were able to accurately measure the quality of their existing provider. "It's fair to say that the quality metrics in community and mental healthcare are poorer than they are in acute services. So if a commissioner says my focus in the next year is on getting a much better grip on the quality of care my patients are being provided by the current provider, we would say that sounds like quite a sensible thing to do".

CQC

The Care Quality Commission is understood to be proposing to appoint three chief inspectors to lead its work regulating health and social care. It is expected that chief inspectors will be appointed with responsibility for hospitals, adult social care and primary and integrated care.

Integration and social care

Care services minister, Norman Lamb, has suggested that part of CCGs' should be used to fund integration with council-run social care services. In an interview with HSJ he said that, as part of preparation for the comprehensive spending review, DH was considering the future use of the 2% of CCGs' budgets which they are required to ring-fence from routine spending. The ring-fenced monies amount to £1.3bn nationally and spending the money is only allowed following appropriate approval by the NHS England Area Team.

Norman Lamb also recently launched a Government care comparison website (as part of NHS Choices) aimed at the public, providing profiles on care services such as care homes. The profiles bring together information from a variety of sources, including:

- official information from the Care Quality Commission inspection reports on care services;
- information from care providers on the specialist services and facilities they offer, with details of staff and other useful information;
- comments from the public, service users, residents and their families on their own experiences of the care provider, including links to other comment sites;
- the ability for the public to give services star ratings.

Labour care review

In late April Ed Miliband announced the establishment an independent commission on whole person care to "find ways of integrating health and social care for the next Labour government so that both of these key public services are affordable in an era when there is less money around than there was in the past".

The Commission is to be led by former DH adviser and GP Sir John Oldham. It will produce recommendations on achieving Labour's vision of 'whole-person care', without another top-down reorganisation and within existing resources.

Sir John told the Local Government Chronicle he was open to all suggestions about "how to create more coordinated and integrated care". He said he would "start out within the framework" outlined by shadow health secretary Andy Burnham, who said in January that he was working on a plan to put the vast majority of NHS funding in councils' control. However, Sir John said: "If people come to radically different conclusions we'll consider them". He said giving more power and responsibility to Health and Wellbeing Boards was likely to be one of the options under consideration.

Sir John stressed that any proposed changes would have to be possible without major structural change. "The NHS is sick and tired of structural change," he said. "It disrupts relationships and that impedes good care".

The other members of the commission include Hilary Chapman, Sheffield Teaching Hospitals Foundation Trust chief nurse; Alzheimer's Society chief executive Jeremy Hughes; Sally Brearley, lay member of National Quality Board and patient involvement expert; Birmingham City Council director of social care Peter Hay; and Marion Dinwoodie, chief executive of Kent Community Health Trust (and a former pharmacist).

ACTION

6. Amendment of the Constitution

The potential for the proposed amendments to allow a subsidiary of a multiple pharmacy group to be elected as an independent representative was discussed. The Review and Audit Panel would examine this issue and other matters related to deputies attending meetings. It was agreed the amendments to 1.2.1 and 1.2.2 of the Constitution would be excluded from the proposed amendments. The other changes to the Constitution and the Rules were approved unopposed.

It was suggested that the issue to be considered by the Review and Audit Panel needed to be undertaken before an election was held. This meant that there would be a delay in starting the election process. If the process was commenced now, it would not be possible to conclude the election before the July meeting.

A vote was taken on proceeding immediately with an election (11 in favour) or alternatively delaying the election until the Review and Audit Panel has examined the issue (12 in favour).

Paul Bennett's resignation from PSNC required the election of a new member of the Review and Audit Panel. Christine Burbage was nominated by Liz Colling and this was seconded by Ian Cubbin. Christine Burbage was duly elected as a member of the Review and Audit Panel.

7. Election of Vice Chairman

Kirit Patel was proposed by Bharat Patel and was seconded by Raj Patel. Kirit Patel was duly elected as Vice Chairman.

8. Pharmaceutical Group of the European Union (PGEU)

The proposal had been made strongly by CPS at the recent quadripartite meeting. Raj Patel said that based on his involvement with PGEU over recent years there were few issues that had direct relevance to the negotiating bodies. He also said that membership of PGEU by CPS alone, on behalf of the other negotiating bodies would not be constitutionally possible. This issue would be

fed back to CPS. If it was possible to successfully address this issue, without the need to create a new organisation, PSNC would happy to proceed with an application to join PGEU.

9. PSNC meetings 2014

The proposed dates for the meetings in 2014 are:

January	March	May	July	October	November
7th + 8th Liverpool	4th + 5th Bath	6th + 7th Leeds	8th + 9th Brighton	7th + 8th London	4th + 5th Birmingham

The balance of meetings held in London and those held in the rest of the country was extensively debated, considering the best use of Member's time and the benefits of greater engagement with LPCs, amongst other issues.

A vote was taken on the proposal to hold three meetings in London and three outside London versus the proposed schedule of meetings above. Eleven members voted in favour of each option and the Chairman cast his vote in favour of the proposed schedule of meetings above, based on the importance of engagement with the LPCs.

It was agreed that RAP should review use of time in the meetings to ensure this was as efficient as possible. It was also agreed that the appropriateness of venues should be reviewed.

RATIFICATION

10. Resource Development & Finance Subcommittee

The minutes of the subcommittee meeting were presented by Mark Burdon.

11. Funding & Contract Subcommittee

The minutes of the subcommittee meeting were presented by Peter Cattee.

PSNC inform the DM+D team when we are aware that prices held are wrong. NCS prices are being monitored proactively. Prices charged by wholesalers may vary by client. The audit of NCSO claims and payments created using data from PSNC's PRISM system was noted and it was agreed that a summary would be generated and communicated widely, along with an update of previous NCSO communications. The issue of whether BSA should return incorrectly endorsed scripts to contractors was discussed.

12. LPC & Implementation Support Subcommittee

The minutes of the subcommittee meeting were presented by Christine Burbage. The recommendation that PSNC send a representative to the PV steering group was briefly discussed and it noted that no commitments would be made without reference back to PSNC. Duplication of activity must be avoided. The recommendation was approved.

13. Service Development Subcommittee

The minutes of the subcommittee meeting were presented by Gary Warner. Three issues were raised:

- A case for vaccination and minor ailment (MAS) services to be nationally commissioned was required. Gary Warner responded that work is already being undertaken for MAS

through SDS. With flu vaccinations, DH are already aware of what community pharmacy can do, and the evidence base should be used to push for AQP, as NHS England is now responsible for commissioning the newly extended national vaccination programme. It should be raised in the discussions with PHE.

- Could further work be done with Monitor on direction of prescriptions? The CEO responded that PSNC was working with DH to tighten the regulations and LPCs had recently been asked to provide evidence of system manipulation. Monitor was open to suggestions to resolve these problems.
- NCSO endorsement cannot be made on an EPS prescription once submitted, which happens daily rather than monthly with non-EPS prescriptions. This needs urgent remedy. The CEO responded that DH accepts changes to the system are needed and are urgently trying to find a solution.

14. Matters of report and any other business

A number of items were noted including a letter of thanks from the DH for PSNC's involvement in the advisory group on NHS Pharmaceutical Services Regulations and the Parliamentary adjournment debate on community pharmacy in which Stephen Pound MP had supported PSNC's vision of pharmacy as the foundation of a third pillar of care within the NHS.

The dates of the next PSNC meeting were noted and Ian Cowan was thanked for his contribution to PSNC and was wished well in his retirement.