OPEN Minutes for Community Pharmacy Herefordshire & Worcestershire Meeting held on 12th March 2026 at Perdiswell Young People's Leisure Club 09:15 – 14:45

CHAIR	Anurag Hegde (AH)
MEMBERS ATTENDING	Wayne Ryan (WR); Akwal Singh (AS); Amritpal Bhamra (AB); Paul Rowley (PR); Nav Matharu (NM); Dhiran Vadhia (DV); Gareth Lam (GL); & Adrian Wilkinson (AW)
IN ATTENDANCE (non-voting)	Fiona Lowe (FL); Zoe Ascott (ZA);
NO APOLOGIES	
GUESTS	ICB: Siobhan Hemans (SH), Caroline Horton (CH), George Eldridge (GE), Anne Hadley (AHa), Conor Price (CP); Jas Heer (JH); Pharmacy Ambassador and PCN Lead WFIP Liz Brooke (LB); Jo Hodgetts (JH) and Christine Price (CP) from the INT Herefordshire programme Remotely – James Wood – Director of Members and LPC Support CPE

Pre main meeting working groups met

Group 1: Executive and CP and Group 2: Governance – Review RAG Assessment and RSG Survey Feedback

CLOSED SESSION

DOI and attendance sheet: Circulated and completed. Full attendance noted

Minutes: January minutes were approved by the Committee

AOB tabled:

Annual review of backfill rate and it was agreed that the current rate was adequate and would remain at £300 per full day backfill, £150 half day and £30 per hour for ad hoc meetings such as the QPMS quarterly meetings with PCNs.

Resignation: JP – resigning from LPC as CCA representative. He was thanked for all of his support.

New term for LPCs – it will be in April 2027, with preparations starting in October 2026 when numbers and make up for Committee will be established. CPE constitution changes may lead to LPC changes.

It was agreed that our two Co-Opted Members AB and NM will remain until the end of the current term, which is the end of March 2027.

Vice Chair position has become vacant due to JP resignation. Agreed that WR will take over the role of Vice Chair, as FL is taking over the role of Treasurer in July. All Members are content. When the new Committee

comes into place all the positions will be reviewed. FL and CP have a 3-month handover and then WR and FL will have a 3-month handover. FL to undertake Treasurer role for 12 months initially with option to extend.

CPE Session:

Jas Heer (JH) (CPE Regional Representative) joins. Refer to CPE slides on Box.

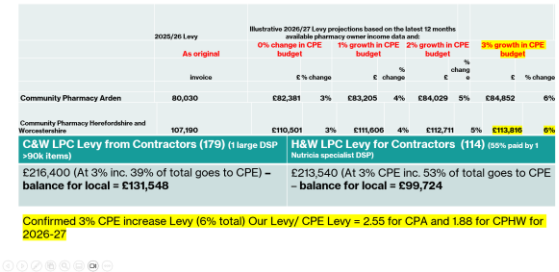
Discussion over the cluster potential merger with Coventry and Warwickshire, and LPCs following the boundaries. It is looking like Coventry will stay in this cluster group, whereas there was discussion of Coventry clustering with West Midlands. Members to consider a merger, there is already a joint team.

- Contract negotiations are under way. A letter was received last Monday. Janet Morrison CPE (CEO) has written to the Health Secretary setting out key asks, supported by collected evidence: (1) close the funding gap; (2) address retained margin and its impacts; (3) clarify how independent prescribing (IP) will be incorporated into the contract; and (4) no new services without additional funding.

CPE - JW joined virtually at 10.30am to discuss levies. He requested to join the LPC meeting following the CPA and CPWM meetings where CPE levy increases were discussed and not well received. Also, in February the Joint Executive met with Becy Butterworth (CPE) where pressure on LPCs was discussed.

- Workload, Financial
- Perceived lack of understanding at CPE that local implementation and ongoing support for national is large part of the work in LPCs but not counted in the value of LPC work – counted as national activity
- Local services are a very small part of the benefit of the LPC to Contractors
- INT and NHSE / ICB changes huge implications with budgets devolved to Collaboratives and Lead Providers

CPE Levies



	2025/26 Levy	Illustrative 2026/27 Levy projections based on the latest 12 months available pharmacy owner income data and:							
	As original invoice	0% change in CPE budget		1% growth in CPE budget		2% growth in CPE budget		3% growth in CPE budget	
		£	% change	£	% change	£	% change	£	% change
Community Pharmacy Arden	80,030	£82,381	3%	£83,205	4%	£84,029	5%	£84,852	6%
Community Pharmacy Herefordshire and Worcestershire	107,190	£110,501	3%	£111,606	4%	£112,711	5%	£113,816	6%

C&W LPC Levy from Contractors (179) (1 large DSP >90k items)	H&W LPC Levy for Contractors (114) (55% paid by 1 Nutricia specialist DSP)
£216,400 (At 3% inc. 39% of total goes to CPE) – balance for local = £131,548	£213,540 (At 3% CPE inc. 53% of total goes to CPE – balance for local = £99,724

Confirmed 3% CPE increase Levy (6% total) Our Levy/ CPE Levy = 2.55 for CPA and 1.88 for CPHW for 2026-27

A robust, confidential discussion was held about levy increases, transparency of budgeting from CPE. JW subsequently provided some information to support the work CPE has completed to support Contractors. Discussion about the one Contractor who pays 55% of our total Levy. CPHW has large proportion of total levy which goes to CPE. CPHW is lowest ratio of all.

Total / CPE levy. Average is 2.5 based on 24-25 accounts and ours was 1.45. The suggestion was that CPHW should increase its levy to provide more funding for local support.

JW leaves meeting.

CEO Report March 2026: Refer to full report on Box

Organisational update: CEO and deputy recruited with handover 1 April–30 June 2026 (increased combined hours). Staffing changes noted (Zoe returning on phased basis; Eva and Susan reverting to contract hours).

INT place-based leads recruited for 12 months using MOU funds (21 hours/month across 5 leads: North Warwickshire & Rugby; South Warwickshire; Coventry; Worcestershire; Herefordshire). Discussion included pharmacy footprint across INTs and expectations of further cluster/ICB changes (including potential INT/cluster consolidation and "left shift" funding referenced for Coventry).

Strategic/structural context: Update from February meeting with ICB Executive/PCC highlighted ICB restructure (fewer director posts; consultation on next layer roles; significant Medicine Optimisation voluntary redundancy). Emphasis on neighbourhood/Place-based collaboratives, ICB role as strategic commissioner/enabler, and potential for additional funding to support shifts in care delivery; NHSE "blueprint" awaited.

ICB, PCN and INT Guests are welcomed and introductions made.
ICB Update:

- Undergoing reorganisation with clustering with Coventry and Warwickshire. Next level is out for consultation, which includes associate directors for Pharmacy and medicines. AHa is taking voluntary redundancy and retiring. Consultation is out until the end of March, then interview and appoint. Then a third wave, whether that is everybody still uncertain. 172 leaving on voluntary redundancy which does help with reducing the staff numbers. There are a lot of people leaving mid-April then June. Communications are being prepared to share with partners. There will be less people to cover a larger geography and a prioritising piece being drafted, have to be realistic on what work can be done. Looking at achieved 66% of target with Pharmacy First Pathway.
- A lot of unknowns. Review and revise work that the ICB does. Teams across HW and CW are starting to try and come together and work. There is a plan that by June all roles and teams will be known. Feeling is positive across the teams at the moment for moving forward.
- Generic emails are still in place and if in doubt should still use those.
- Further discussion over the restructure. Positive that the LPC cover both areas.
- Office of West Midlands going through a similar process but believe it is being paused.
- Reducing costs and getting to £19.60 per population.
- David MeHaffey is leading digital agenda
- Better Care Fund (BCF). It was noted that community pharmacy has been presented to the national BCF team in London, highlighting the role and benefits of community pharmacy. There may be an opportunity to support local work in this area, particularly given BCF overspends in both Herefordshire and Worcestershire and the current reform discussions. JoH offered to discuss this further, including how community pharmacy could help address the overspend. Digital: it was noted that one of eight national digital workstreams with NHSE is exploring what good digital support for neighbourhood health should look like; the NHSE digital landscape and current team activity were discussed. CP to follow up.

AHa - Hereford BCF managed by the Wye Valley Trust and Council, not the ICB. Follow up. Value for money invest in BCF providers, does need a shake-up. AHa to follow up.

- CP – discussion on utilising the services already available through community pharmacy.
- CH provided an update on the pregnancy incident: Phase 1 has identified the pharmacies involved and is still being managed by the Office of the West Midlands. Pharmacies were asked to respond to communications, as some have been contacted multiple times. FL requested a list, CH confirmed that 5 remaining pharmacies to respond and will share the list and communication. Phase 2 will cover all remaining pharmacies ('mop up') and also requires responses. Compared with other ICB areas, HW/CW response levels are relatively low. The issue remains ongoing and communications will continue to come from the Office of the West Midlands.

National Neighbourhood Health Implementation Programme (NNHIP) with JoH jo.hodgetts@wvt.nhs.uk

(see slide deck shared after LPC)

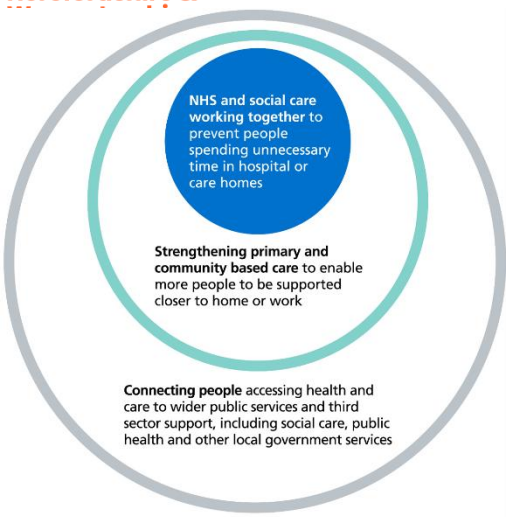
Neighbourhood Health is about making care more personal, more local, and more focused on what really matters to people, so everyone can live a healthier, happier life.

Instead of just treating illness, Neighbourhood Health looks at everything going on in someone's life, like stress, money worries, loneliness, and it help with what is getting in the way of a person living well.

The purpose of NNHIP is to **accelerate a national shift to proactive, integrated, neighbourhood-based models of care** that improve outcomes, reduce avoidable demand, and empower communities while using learning from real places to shape national policy and spread change at scale

What are Herefordshire's key NNHIP deliverables?

1. Establish and accelerate delivery of a new model of multi-disciplinary neighbourhood teams working with individuals from targeted cohorts (people with multiple long-term conditions and rising risk)
2. Achieve measurable improvements in health outcomes and tangible improvement in key metrics for targeted cohort
3. Build leadership capacity across the system
4. Develop stronger governance and accountability at place
5. Test and develop new contractual and financial models



NNHIP – Herefordshire one of the first 43 sites.

jo.hodgetts@wvt.nhs.uk

Christine Price – Healthwatch Herefordshire

The group discussed how to build a strategic partnership to strengthen and maintain a focus on prevention, noting that community-based working is essential but not straightforward. It was observed that when stakeholders see other parts of the system first-hand, it becomes clear that organisations often have limited understanding of each other's roles and of the reach and potential of community pharmacy. Members agreed that community pharmacy needs to be represented in key discussions. FL advised she is developing an information pack and welcomed feedback. Gareth Lam was noted as the Neighbourhood Lead for Herefordshire. **Action:** Christine Price and Jo Hodgetts to review the pack and provide feedback. Induction for Leads will take place on 23rd March. Governance arrangements are being reviewed. FL requested involvement in One Hereford. The May LPC meeting will be held at Taurus offices in Hereford.

Discussion over Hereford coterminous make up, and why this works.

Challenges: Complications surrounding IG. CP – would have been a missed opportunity for Pharmacy to not be involved in NHHIP. Difficulties in sharing data. FL – need CP to be at the decision-making point. Further discussion on what pharmacy could add and barriers on getting in. LPC do feel like the door is open with Herefordshire.

Neighbourhood Pharmacy Ambassadors

Manisha – discussion over not a new idea but again there needs to be the CP presence, for other organisations to understand what CP do and can offer. Discussion over the relationship that CP and patients have and how CP get forgotten. Qualitative data will be rich coming from CP. Discussion over value for services when people do not know about them. This approach should help to broaden the narrative and why Community Pharmacy needs to be present.

JoH – capacity discussed. Happy to discuss further with LPC. SharePoint access is set up. LPC to link up with JoH

NM – discussion over referral process for GP/Pharmacist discussion. JoH – does not have level of detail on services. CP – good example in a neighbourhood is the relationship between GP and CP – all BP checks to go to CP and results go back to GP (caution changes in specification due) and action taken from there depending on result. JoH – assumption that there just isn't the knowledge there. All pharmacy services were shared previously.

CP – usual to get in on the market stalls. IT is a national problem – understanding the value of CP.

Jas H – historically had an issue with supervision and pharmacists being able to leave the building. There may be a change in this, supervision going to technician and also learning time is being discussion nationally. This could facilitate this local neighbourhood working.

Look at setting up a meeting with local pharmacies in Hereford with JoH.

JoH and CP were thanked for their contribution and then leave the meeting to return for lunch.

Medicines Supply

Discussion over Short supply, switches and the impact on Contractors and General Practice. DOACs – issue. Big issue changing from Novarapid, and a lot of out of stocks.

PCN Pharmacy Leads – discussing the switches. Price discrepancy (losing money by switching). Shortages, GP pharmacy teams deal so much time dealing with shortages and having to switch to more expensive products temporarily. It is a big source of frustration in General Practice. Raise in context of the mergers and other issues going on. Hoping the HW influence of not switching rubs off on the CW side of the cluster merger. AHa – moving towards a commissioned service approach. Try and keep switches to a minimum.

Worry with less capacity in the ICB to monitor the PCN pharmacist activity with switches.

Further discussion on switches, preferred brands and dispensing at a loss.

Branded Generics – a small amount in HW of preferred brands.

JH – overall branded generics cost the NHS over 150 million a year. Information has been fed to NHS Central.

Hope that pricing does settle. Wholesalers discussed.

Members to give examples to ahwlpc@gmail.com email to feed back.

Push back of prices being below tariff prices from certain wholesalers. Supply and demand need to also be considered.

Liz Brooke – preference would be high volume switches that would not cause a problem and show that no/few others would need to be done.

FL – look at forming a group to look into this across CW and HW. Look at what can do to reduce shortages, not unnecessary switches. – JH, LB, NM, AB & CP – and feedback to AHa. Meeting set up and draft paper prepared.

JH – pushing for pharmacy flexibility as well. Professional exemption where could switch and just notify the surgery. Especially with items that would not have a problem.

Discussion how it can benefit pharmacies from the margin. Complicated system.

Number of switches – smaller numbers.

Communication to patients is important as well with the switches.

JoH and CP rejoin

Break for Lunch

All guests leave after lunch

OPEN AFTERNOON SESSION

Visits planned for this afternoon.

Governance Group completed RSG questionnaire and the RAG which was shared and then completed on CPE template after the meeting.

- Pharmacies have been aligned to INTs and the mapping has been shared.
- An information pack is being developed for distribution.
- The May LPC meeting will take place in Hereford at the Taurus Hub.
- Induction for INT Leads is scheduled for 23rd March.
- The group discussed appropriate starting points for neighbourhood team engagement.
- A communications plan needs to be agreed.
- It was noted that INT structures vary significantly.
- The Discharge Medicines Service (DMS) was identified as a good fit for neighbourhood working.
- The Vulnerable Patient Scheme was noted as a relevant area of work.
- The group considered who is doing what, where representation is needed, and whether the LPC is on the right committees.
- It was suggested that attendance at meetings should be tested to confirm value and relevance.
- Members agreed there is a need to increase the visibility of community pharmacy.
- Examples were discussed where community pharmacy could proactively offer support (e.g., reducing readmissions or managing sore throats).
- NM shared experience from INTs in the Black Country, noting frequent requests to demonstrate how community pharmacy can help. Members highlighted the need to engage with the right teams and maintain a presence in meetings.
- MS highlighted the need for stakeholder mapping: who the LPC wants to influence, and how to ensure messages reach the right audiences.
- An action was noted to identify Jo Hodgetts' counterpart in Worcestershire.
- CP noted that the implementers in Worcestershire are known and suggested starting there. It was emphasised that community pharmacy needs to be in the right meetings to challenge misconceptions and drive change, recognising that primary care is broader than general practice.
- Further discussion took place on attending the right meetings, rather than trying to attend every available forum.
- It was suggested that the Annual Report should include a substantive section on neighbourhood working.
- A patient-facing Herefordshire and Worcestershire website is currently being developed.
- Members noted that unfunded activity cannot be sustained.
- It was noted that community pharmacy already undertakes significant signposting.
- An education/awareness gap was highlighted, with the wider system not consistently understanding the role and contribution of community pharmacy.
- The Worcestershire alliance of community groups was noted as a potential route for engagement (e.g., via newsletters).
- External communications approaches were discussed.
- NM noted that INT meetings can be GP-heavy. The group discussed developing a consistent set of key messages for leads to raise.
- Provider organisations sitting within federations were discussed, including whether additional infrastructure is needed to support new ways of working.

- The group discussed building confidence to contribute in GP-heavy forums. CP expressed concern that neighbourhoods could become 'PCN 2.0', noting this is not the intended model; wider discussion followed on PCN effectiveness, achievements and lessons learned.
- The group discussed developing a consistent 'community pharmacy message', drawing on existing materials and agreeing local adaptations as required.

NB: CCA Questions: on Box

14:45: Meeting closed and Members went to complete pharmacy visits

Meeting Minutes approved by committee on 14th May 2026.