

Getting to grips with the LPS scheme

In this article Gianpiero Celino and David Reissner explain the local pharmaceutical services scheme in detail, covering the background behind the scheme, what it provides and how contractors can get started

Until 2003, community pharmacy owners could only provide NHS services under a national (PhS) contract. The local pharmaceutical services (LPS) scheme was introduced in 2003 as a means to test new ways of working in community pharmacy. Initially a pilot programme, LPS arrangements were made permanent through regulations laid before Parliament in April 2005.

After an initial flurry of activity, interest in LPS declined, but the concept remains a tool in the armoury for those seeking to innovate in the provision of pharmaceutical services. Recently, interest in LPS has been renewed due to the protection that it offers contractors from the threat of 100-hour pharmacy applications.

In the absence of guidance from the Department of Health (DoH), contractors and primary care trusts may find regulations relating to the LPS scheme cumbersome and complex. This article attempts to answer questions that have been raised by PCTs and contractors grappling with the LPS framework to allow them to develop their plans.

Doing things differently

The intention, at the time of its introduction, was for LPS pilots to inform the thinking around the new contract while providing an opportunity for innovative PCTs and contractors to widen their horizons. LPS appealed to pharmacists and PCTs who wanted to “do things differently” and, in this respect, provided a framework for experimentation and innovation in which contractors and PCTs could, for the first time, include dispensing as part of a service redesign. As the new contract drew closer, both PCTs and contractors shifted their focus to anticipating and preparing for the changes that this would entail. This inevitably led to a drop in LPS proposals.

Renewed interest in LPS

Interest in LPS is growing once more as contractors, looking beyond the new contract, consider their options; small-volume contractors look to offer added-value service; pharmacists with a special interest look for a framework in which to provide their services; and concerned contractors look to protect their pharmacies from the threat of an application under the exemptions to the control of entry rules (see Panel 1).

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The new contract introduces specific LPS changes, particularly the essential small pharmacy LPS (ESPLPS) scheme for isolated pharmacies. This scheme is shortly to be replaced by low-volume LPS arrangements.

Although LPS, ESPLPS and low-volume LPS share a common platform, they are essentially constructed to achieve different things. ESPLPS and low-volume LPS are intended to safeguard the provision of pharmaceutical services where dispensing volumes alone are not sufficient to support a service. LPS is not limited to low-volume contractors.

What is LPS?

LPS provides a mechanism for the commissioning of community pharmacy services outside the national contractual framework for community pharmacy. LPS includes a range of services such as medication review, out-of-hours and specialist drug-misuse services.

Essentially, individual implementations of LPS share the following common characteristics:

- A local contract between a PCT and a contractor to provide dispensing services to a defined patient group or groups, to commission other services to patients and to specify the terms under which the PCT will pay for these services
- A service-delivery plan setting out the objectives for the service, the intended outcomes and the performance-management arrangements
- Transfer of funding from the global sum to the PCT

What LPS cannot do is:

- Alter the arrangements for the pricing of prescriptions; these must be submitted in

the usual way to the Prescription Pricing Division

- Alter the arrangements for the reimbursement of medicines — the Drug Tariff still applies
- Alter the legal framework for the supply of medicines and the Medicines Act (other relevant legislation still applies)

Putting PCTs in the driving seat

Initially all LPS applications were subject to local and national scrutiny before being approved by the Secretary of State through an application to the DoH. One of the consequences of making LPS permanent has been to remove the DoH from the decision-making process and to shift this responsibility onto PCTs. This places an obligation on PCTs to ensure that they have adequate procedures in place to review and determine LPS proposals fairly, equitably and transparently.

Taking LPS forward

Typically, PCTs or individual contractors now have the responsibility for taking forward their ideas for LPS initiatives. What is important is that for any LPS proposal there is a clear benefit for patients, the PCT and the contractor. Taking forward an idea will involve work for both PCTs and contractor (see Panel 2).

Guidance from the DoH advised PCTs that they should first decide whether they are open to LPS proposals from contractors or whether they will consider developing a PCT-led proposal. This provision was to prevent unnecessary work by contractors who might be interested in LPS but where their PCT was “closed”. This guidance is still in force and places PCT in the driving seat for LPS.

Options for LPS proposals

There are three types of LPS proposal:

- Application to provide a new service — typically where a pharmacy service does not presently exist — or provide current services by innovative means
- Application to convert a PhS contract to a LPS contract
- Application to provide LPS alongside a PhS contract

The type of proposal made will be a matter for the applicant. This is discussed later in more detail.

PCT processes

Once a PCT is ready to proceed with a LPS proposal it can be invited to designate a geographical area as a neighbourhood and to

Panel 1: Control of entry

Normally, anyone wishing to provide NHS services from a new pharmacy must satisfy a restrictive test of necessity or desirability in order to secure adequate pharmaceutical services. The NHS (Pharmaceutical Services) Regulations 2005 introduced exemptions to this test for four types of application, the most common of these from pharmacies open at least 100 hours a week. There are few ways in which applications for these kinds of contracts can be rejected. However, PCTs cannot grant applications that would otherwise be exempt from the necessary or desirable test if there is, or will be, LPS in the neighbourhood.

Panel 2: Work required of PCTs and contractors

PCT	Contractor
<ul style="list-style-type: none"> ■ Determining the merits of the proposal ■ Undertaking the impact assessment ■ Consulting on the proposal ■ Commissioning the service ■ Accounting to the DoH for the money allocated from the global sum ■ Funding the service ■ Determining the right of return 	<ul style="list-style-type: none"> ■ Developing the proposal ■ Preparing the service design ■ Undertaking training ■ Reorganising the work of the pharmacy to accommodate the service ■ Liaison with the PCT

defer considering any applications for new pharmacies (including 100-hour pharmacies). The purpose is to maintain protection for the LPS arrangement against applications which, if granted, might undermine the ability to achieve the LPS objects.

Negotiations with the PCT will cover fees and other contractual terms. A formal contract needs to be drawn up and all contracts have certain standard arrangements. It would be prudent to seek legal advice over these. It is possible to obtain, from the PCT, payment to cover expenses that are incurred in preparing the LPS.

Forms

There is no prescribed format that an LPS proposal should follow. However, PCTs should give some thought to the minimum data-set that provides sufficient information for considering an application. The PCT's application form for entry on to the pharmaceutical list is a good starting point for developing an LPS application form.

Headings that should be included on an LPS application form (a sample LPS application form is available from the authors by emailing gc@webstar-health.co.uk):

- Applicant details
- Fitness-to-practise declaration
- Premises details
- Proposed opening hours
- Summary of the proposal
- Aims of the LPS contract
- Need for the LPS contract
- How the LPS contract will work
- Contractual arrangements
- Costs and funding
- Performance management

Contractors will want to ensure that they provide the PCT with a full picture of the services that they intend to provide, the rationale for these services, the links to local or national priorities, evidence that other stake-

holders in the service have been consulted and are supportive, the measures that will be used to monitor the progress of the service, the timescale for its launch and potential developments.

Timescales

Generally PCTs should ensure that LPS applications are dealt with efficiently and in a timely manner. The benchmark set for conventional pharmaceutical services applications (four months) is an appropriate target.

Impact assessment and consultation

PCTs are required to consult on all LPS applications. The regulations stipulate a minimum period of 30 days. This contrasts with the requirements for PhS applications which must undergo consultation for 45 days. A proposal to provide LPS should be subject to an impact assessment which should be documented and circulated with the proposal for consultation. The impact assessment and the LPS proposal should be circulated to:

- Dispensing contractors that may be affected (both pharmacies and GPs)
- Neighbouring PCTs where the premises or neighbourhood are near to a border with another PCT
- Local pharmaceutical committee
- Local medical committee
- Patient representative organisations

Decisions and appeals

PCTs will need to put in place a procedure for receiving, reviewing and processing LPS applications. This need not be substantially different from the process for determining PhS applications. DoH guidance advises that the responsibility for the decision rests with the PCT board, but that the board should delegate this role to a committee that has broad professional, PCT and lay membership. This could be achieved by inviting individuals to join the PCT's pharmacy panel. The de-

cision of a PCT to approve or reject a proposal to provide LPS needs to be based on sound criteria and have been arrived at in a transparent manner, and without conflict of interest. There is no right of appeal against a decision by a PCT, so legal advice should be sought if a prospective provider of LPS services, or an objector, is aggrieved by a PCT decision.

Key considerations for applicants

Full LPS or side by side One of the decisions for an existing PhS contractor who is considering offering LPS is to decide whether to relinquish their PhS contract or to operate on alongside their PhS contract. The former means that all the contractor's existing dispensing business plus any new business arising from the LPS contract will be paid by the PCT direct. The latter means that only dispensing and other services associated with the group or groups of patients defined in the LPS proposal will be paid directly by the PCT.

Dispensing allocation The establishment of LPS will involve a transfer of funding from the global sum to the PCT for an amount equivalent to that which would have been paid for the dispensing undertaken by the LPS provider under the PhS contract. How this money is then used in the LPS scheme is subject to the terms of the contract between the PCT and provider (see Figure 1).

Right to return Where a contractor has relinquished his or her PhS contract in order to enter into an LPS contract at the same premises or neighbourhood, then the contractor has a right to return to the PhS contract at the end of the LPS contract period subject to the terms of the right of return set out by the PCT. It is important that the contractor is happy with the terms of the right to return before entering into a contract with the PCT.

Minimum requirements for LPS The LPS scheme must have, as a minimum, the following characteristics:

- Provide services to patients
- Undertake the dispensing of prescribed medicines — although this may be for a defined patient group
- Have a contract between the provider and the PCT that deals with fitness to practise, dispute resolution, a complaints procedure, and the dispensing and pricing of prescriptions
- Be consulted upon before implementation
- Be approved by the PCT

Conclusion

LPS has moved from a pilot scheme to a permanent feature in the pharmacy commissioning arsenal. The impact on pharmacy applications that would otherwise escape control of entry means there is renewed interest in LPS by PCTs and contractors.

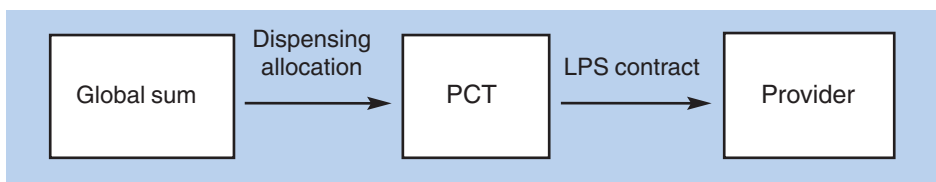


Figure 1: funding flows in LPS