

Practice-based commissioning views

A breakfast session at BPC focused on the new way in which health care services are to be commissioned in 2006. **Lin-Nam Wang** reports

Next year is set to be one of change as the plans in "Commissioning a patient-led NHS" are implemented (*PJ*, 15 October, p476). Trish O'Gorman, assistant director for primary care contracting at the National Primary Care Development Team, explained that the aim is to drive forward more changes in commissioning structures in order to achieve the vision for primary care. "The key driver was to look for more and better engagement with local clinicians for the design of services," she said. There have been discussions about how much professional executive committees have been able to facilitate that kind of change. "I think there may be changes this year in terms of PECs ensuring that all clinical groups are represented on [them]. It is about making sure they have some kind of teeth and can develop and deliver change," she added. And, in essence, there will be "a reconfiguration of primary care trusts to ensure fitness for purpose."

The issue of practice-based commissioning and the changes related to it elicited several different responses from delegates. Rob Darracott, director of corporate and strategic development at the Royal Pharmaceutical Society, voiced a concern over the uncertainty of what would happen to people's jobs. "I do not see how a workforce of up to a quarter of a million people can be incentivised to be at the heart of this and make it work if, in three months' time, they might not have a job any more because it has been restructured out of the system," he said.

Alistair Buxton, head of NHS services at the Pharmaceutical Services Negotiating Committee, expressed concern about losing pharmacists on PECs and PCT employees, with whom good relationships had been established.

The issue of opportunities for pharmacy and how pharmacies could keep ahead was

also discussed. For example, pharmacists could think about the alternative provider medical services (APMS) contractual route. "The APMS offers opportunity for other organisations to employ GPs to provide of primary medical services. I think developments in this area are particularly exciting for community pharmacy," Ms O'Gorman said.

Beth Taylor, principal pharmacist at Primary Care Contracting Southwark PCT, is optimistic that there is potential for commissioning services through community pharmacy and establishing wider diversity. However, she said that her experience with supplementary prescribing has made her more cautious because "it has proved exceptionally difficult to persuade GPs to directly fund activities to do with prescribing from pharmacy contractors." Mrs Taylor questioned why practice-based commissioning would be any different and whether or not the commissioning framework requires practice-based commissioners to attain a set proportion of their services outside direct employment but within the locality. The answer to this is that there is no target in terms of provision. "It is a tricky problem," Ms O'Gorman acknowledged.

According to Sue Kilby, head of practice at the Society, this is a time of change and a time of opportunity, but pharmacy needs to be positioned more appropriately.

One solution might be to raise the general awareness of all pharmacists of how the NHS is changing, Mr Buxton suggested. "A lot of jobbing pharmacists have their heads down at the dispensing bench or are working away in PCTs or practices and they just do not have a thorough enough understanding of how the NHS is working and how it constantly changes. If we cannot understand it in the profession, we are not going to be able to maximise the opportunities that are being presented," he said.



Trish O'Gorman: if practice-based commissioning takes off, it could help redesign services

Ms Kilby suggested also looking at management skills. "Pharmacists do not need just their knowledge as a pharmacist. They also need certain levels of management skills as well and if they have those, they will be able to manage change," she said.

Angela Alexander, senior lecturer, University of Reading, said that another problem is that employee and locum pharmacists do not have the same incentive as GPs for service redesign. She suggested that management models within multiples be taken forward to incentivise pharmacists to take on the new vision of pharmacy.

Alzheimer's care could be an enhanced service

Dementia care will fit into an enhanced service model, Dawn Price, chief trust pharmacist at South of Tyne and Wearside Mental Health NHS Trust, said at a session on Alzheimer's disease and other neurological conditions. The core development of any medicines management pathway centres around a single assessment process (SAP). Dr Price pointed out that pharmacists need to take note of the fundamental flaws and barriers that could prevent the SAP from increasing concordance. There was no involvement of pharmacists in developing the SAP. Moreover, there is no linking of either primary or secondary

care pharmacists with the SAP. The ability of the initial assessor (a non medically qualified individuals) to identify a patient's needs should also be questioned — research has shown that there is a potential to miss a patient's needs.

Dr Price expressed hope that the new pharmacy contract reforms will improve access and quality of care but "We need to develop specialised services across the clinical boundaries and get community and hospital pharmacists working together," she said.

The vast majority of people with dementia are in the community and it is a myth that they

are sitting in residential or nursing homes, Peter Passmore, consultant physician, Queen's University, Belfast, said. Giving an overview of treatments for Alzheimer's disease, he warned that acetylcholine inhibitors are the only drugs licensed to manage neuropsychiatric symptoms in dementia, and risperidone, olanzapine and quetiapine are not.

Dr Passmore also commented that patients who want to take vitamin E as an antioxidant can be advised that it does not give much benefit in dementia. In addition, vitamin E is not non-toxic — it can cause bleeding and bruising, especially if a patient takes aspirin.