

Local pharmaceutical services: a new threat or an opportunity for pharmacy?

The Department of Health issued guidance on local pharmaceutical services contracts on 26 April (see p597). Speakers at the Institute of Pharmacy Management International's conference, held in Salisbury on 27–28 April, were divided on whether LPS represented a threat or an opportunity for community pharmacy (see p606). Jonathan Buisson reports

LOCAL pharmaceutical services are an alternative legal way of providing pharmaceutical services under the National Health Service. Promised by the Government as part of the NHS plan for England, and included in the pharmacy plan, LPS will allow primary care trusts to contract for new services or combinations of services to be delivered through community pharmacies alongside a traditional dispensing service.

The development of LPS has been driven by the Department of Health, not the pharmacy profession. There is general agreement that the current pharmaceutical services (PhS) contract is no longer working well and that it contains perverse incentives that impede the development of better services for patients. Pharmacy's negotiators would prefer to see a new national contract, including agreed additional services for local implementation, rather than a series of differing local contracts. This is the model that has been used by general practitioners in their negotiations for a new contract. (*The Journal* will be looking at the new GP contract in more detail shortly.)



Local pharmaceutical services pilots could be used to provide more services for elderly patients

PCTs IN THE DRIVING SEAT

LPS contracts will be between primary care trusts and LPS providers. Providers will have to employ pharmacists to do any dispensing in the normal way, but they do not have to be pharmacy companies or existing contractors themselves.

PCTs will be in the driving seat for LPS. It is up to each PCT to decide whether it wants to establish any LPS pilots in its area. Concern has already been expressed that with all the changes taking place in the management structure of the NHS in England this year, LPS will not be a high priority for hard pressed PCT boards.

In addition, no new money is to be provided for running LPS pilots (although some is available for preparatory work). With PCTs having already set budgets for the current financial year, money for LPS may be difficult to obtain.

Dr Brian Curwain, chief pharmacist at New Forest PCT, backs this view: "Many PCTs will not have thought much about LPS until now. Few will want to go for the first wave of applications in June. Some may work towards November, but I think it is unlikely that many LPS pilots will start before April 2003."

If a PCT board does choose to accept LPS bids, then it is obliged to consider all the bids offered to it. It can even develop its own outline bids before finding a suitable LPS provider (PCTs cannot themselves be

LPS providers). However, the PCT is under no obligation to approve any outline proposals for further development, as long as its decision making process is clear and transparent.

WHAT COULD LPS OFFER

The aim of LPS is to design integrated local arrangements, freed from the restrictions of the current PhS contract, that implement the key objectives of the NHS plan. These include giving better access to services, helping patients get the most from their medicines, redesigning services around patients and ensuring high quality services.

The kind of services that have been suggested as potential LPS pilots include providing a centralised out-of-hours dispensing service for a PCT area, perhaps running alongside out-of-hours medical services; encouraging pharmacies to relocate into currently under-served or deprived areas; or running diagnostic and monitoring clinics for patients with specific diseases such as asthma, diabetes or heart disease.

Dr Curwain says that LPS offers community pharmacists an opportunity to get involved in schemes, such as medicines management reviews, that might reduce prescription volumes without being penalised financially as they would be under the existing pharmacy contract. "LPS is not about increasing pharmacists' total income, it is about taking on new roles."

From patients' point of view, pharmacy services provided under an LPS should look largely the same as before, in that current arrangements for prescribing, prescription charges and exemptions, and standards of dispensing will still apply; it will just be that there are some additional new services for them to use.

LPS IN SCOTLAND

The Scottish strategy for pharmaceutical care says that the Scottish Executive Health Department will seek powers to introduce local pharmaceutical services. However, Frank Owens, chairman of the Scottish Pharmaceutical General Council, says that there has been no discussion of LPS with the profession.

"The strategy suggests that where there are gaps in the pharmaceutical service, the Health Department may look to LPS to close the gaps. It would look to existing contractors to undertake these schemes, rather than new entrants, so as to make the best use of existing community pharmacies."

Whether there will be a large number of pilots approved anywhere in the country, or even lots of new entrants to the pharmacy market, only time will tell. However, LPS does offer pharmacists an opportunity to shape their own services for their own areas. Successful LPS pilots could pave the way for the negotiation of nationally funded new community pharmacy services.

LPS: an opportunity for us or for the Americans?

Whether existing contractors or new entrants to the pharmacy market would gain most from LPS was discussed by the IPMI

WITH new guidance being issued by the Department of Health at the end of last week (see p597), a lively discussion ensued at the Institute of Pharmacy Management International's conference that weekend, with several speakers covering the theme of local pharmaceutical services.

AMERICAN REVOLUTION

"What is the most extreme thing that could happen under LPS? The Americans are coming," declared Dr Darrin Baines, director of medM, opening his presentation to the IPMI's conference.

LPS is a change in the law surrounding community pharmacy and, as such, is a change in the rules by which pharmacy is played. It also allows new players to enter the market for providing pharmacy services.

"Five years ago, I went to Australia to look at its health care systems. I found that over a third of them were being run by American managed care organisations. As soon as they realise that LPS is up and running in the United Kingdom, they will be here to run managed care systems for primary care trusts."

American companies have advantages over UK pharmacists in that they are used to staying within business budgets, rationing access to medicines, developing and using performance management systems and negotiating contracts with health care purchasers, Dr Baines said.

Some support for this proposition was given by Michael Keen, a member of the IPMI's council, in a discussion session on options for remuneration.

He pointed out that many American pharmacy benefit management (PBM) companies are already involved in negotiations between pharmaceutical companies, health care purchasers, funders (including governments) and pharmacists.

PBMs negotiate rebates on the prices of pharmaceuticals in return for their inclusion on agreed formularies. They promote generic substitution, disease management programmes and mail order services. Developments in information technology allow them to provide pharmacists with information about patients' insurance plans, necessary co-payments and relevant formulary restrictions. Payments for dispensing can be made online. Current trials with electronic transfer of prescriptions in the UK show that similar IT systems could eventually be established here, Mr Keen said.

However, with no new funding being made available for LPS pilots, he sounded a note of caution: "Cash-strapped PCTs may not be the best start for LPS — don't take your eyes off the national contract."

The development of LPS is, according to the Department of Health's guidance, designed to allow "integrated local arrangements which address local priorities and meet local needs" in a way not possible

under the existing contract. However, even the Department itself notes that innovative local schemes have been introduced as additions to the national arrangements.

One such scheme is the Barking and Havering medicines management project for the elderly (*PJ*, 16 February, p197). This £500,000 scheme was negotiated directly with Barking and Havering Health Authority. Hemant Patel, chairman of Barking and Havering Local Pharmaceutical Committee, was one of the driving forces behind the project. He told the IPMI's conference: "Where there are good pharmacists and good PCTs, then we can achieve things, even without LPS."

The Department of Health's decision to establish LPS is a reflection of a new, more proactive approach to running the NHS, Mr Patel said.

Pharmacists need to get involved with collecting data that will allow PCTs to carry out health needs assessments of their populations. "If you are not involved in collecting data, you will not be involved in its assessment and you will not get any funding."

CARE OF THE ELDERLY

Looking at what services might be offered under LPS contracts, Mr Patel said that care of the elderly would be a huge chunk of the market.

"I can see all the nursing homes in a PCT area being looked after by two doctors on a personal medical services contract. It would only need one pharmacy to supply them under LPS."

Mr Patel said that pharmacists need to

ensure that they have the right competencies for running services under LPS. He identified the key competencies as pharmacy skills, learning skills, change management, relationships, and negotiating.

Standards within primary care are being driven by national service frameworks. Looking at the NSF for Older People, Mr Patel identified several areas where pharmacists could make a contribution through potential LPS schemes. These were:

- 1 **Needs of patients** Designing individual care packages
- 1 **Needs of populations** Packages for ethnic minorities or carers
- 1 **Intermediate care** Preventing unnecessary admissions to hospital
- 1 **Rehabilitation** Ensuring early discharge from hospital without readmission
- 1 **Preventing falls** Osteoporosis assessment and treatment

Mr Patel said that a trial of osteoporosis management through pharmacies had been undertaken in Barking and Havering.

Godfrey Horridge, financial executive of the Pharmaceutical Services Negotiating Committee, said that the PSNC is happy for a modest number of LPS pilots to be established. It will help any contractors who want to be part of one.

"PCTs will have to pay for everything except dispensing in LPS pilots — but you would be mad to accept current dispensing costs," he warned.

Negotiations are just getting under way for a new national pharmacy contract which may include new services.

How to make an outline bid proposal for LPS

Primary care trusts will be obliged to consider all outline proposals for local pharmaceutical services pilots that are submitted to them. However, they do not subsequently have to approve or fund any of them, so long as their decision-making process is clear and transparent.

An outline proforma is available from the Department of Health's website (www.doh.gov.uk/localpharmaceuticalservices/proforma.pdf). Those applying will have to supply the following information:

- 1 Provider's name and contact details
- 1 Location from which LPS service will be provided and whether such premises are registered retail pharmacies
- 1 Pilot aims, patient needs to be addressed and how, contractual arrangements, benefits to patients, contribution to local health priorities, and emerging views from initial discussions with stakeholders
- 1 Total cost and dispensing element cost
- 1 Any other additional information requested by PCTs

Assuming that the PCT has itself taken the decision to use LPS in its area, there is then a five-stage process for the development, scrutiny and sign-off of outline proposals and their subsequent development into full proposals for approval by the Secretary of State for Health. Once approved and implemented, usually three months after approval, PCTs will have to publish details of their schemes. Each scheme will have to be reviewed at least once within three years of starting and a national evaluation of LPS pilots will also be undertaken.