BMA

England

Focus on Dispensing and Prescribing

Summary
Dispensing GPs provide primary healthcare to around 9.9 million rural patients. Of these, approximately 3.5 million patients live far enough from a community pharmacy to allow a dispensing doctor (GP) to dispense medicines for them, if so requested.

Only certain patients are eligible to receive dispensing services from a dispensing doctor; in total, around 7% of all prescription items are dispensed by doctors. Patients receiving dispensing services must live in a designated area and be a set distance from the nearest pharmacy (see below).

The unique benefits of the dispensing doctor service are that it provides access to medicines and general healthcare under one roof.

There are a total of 1,107 dispensing practices across Great Britain (including Scotland), which make up approximately 13% of all general practices, supplying medication to around 3.5 million NHS patients. Dispensing of medications is a service valued by patients and significantly contributes to the financial stability of rural dispensing practices, according the DHSC Cost of Service Inquiry in 2010.

The issues facing dispensing doctors come under four broad categories:

Reimbursement
Dispensing doctors need a new agreement on drug reimbursement costs. The DHSC, in negotiation with Community Pharmacy England, has negotiated a new system of reimbursement. Dispensing practices purchase drugs in the same market-place, but are currently being reimbursed on different, less advantageous terms. When a practice buys drugs, they are subject to a 'clawback', which is now economically unrealistic. Consequently, some practices are prescribing drugs at a loss, which is an unacceptable position. Therefore, a new agreement on drug reimbursement costs and processes is urgently required.

Remuneration
Remuneration must also be addressed. The current fee scale negotiated in 2012 was only ever intended to be a 'stop-gap' interim measure. Dispensing doctors are using a methodology agreed in the low-inflation era that is no longer fit for purpose. It is the view of the Dispensing Doctors Association (DDA) and GPC England that the current proposals on remuneration are based on flawed, inaccurate data. In recent years there has been seen to be a 'yo-yo' effect with large variations seen across the fees scale. This is causing financial instability and presenting cash flow issues for such dispensing practices. This therefore needs to be updated.

Regulations
Currently, according to the regulations in England and Wales, a practice must be in a 'controlled locality' to dispense, which is predominantly rural in character and where the patient is more than 1.6km from a pharmacy.

If a pharmacy applies to open within such an area, there are a series of regulatory hurdles which must be passed. Subsequently, if approval is given, there is a period of 'gradualisation' for a practice to progressively reduce its dispensing.

The current system is stable and understood by both professions. A number of dispensing practices have applied to open their own pharmacies as a means of protecting both their dispensing patients, and the ongoing viability of their GMS services. The 2010 cost of service inquiry (see above) showed that dispensing income is being used to subsidise GMS activity.

Recently there has been a problem relating to English practices with 'historic rights' i.e. those granted dispensing rights prior to 1983, which has been the subject of a meeting between the Department of Health and Social Care (DHSC), DDA, and Community Pharmacy England (CPE). GPCE understands that the DHSC is not presently minded to change the regulations, being content with the interpretation proposed by the BMA and DDA. We continue to meet regularly with CPE to ensure there is no conflict between our professions.

Rurality
There is an urgent need to discuss the role of dispensing practices in the provision of GP services in remote, rural and coastal communities. Rural healthcare tends to be more expensive, and the levels of demand can be markedly different to urban areas. As per above, evidence suggests that for some dispensing practices, the dispensing income subsidises the costs of providing primary medical services in such rural areas.

One of the problems is attracting qualified individuals to these remote geographies, and that requires providing training opportunities, as clear evidence suggests GPs will frequently stay to practise in the area in which they undertook their vocational training scheme. Thus, GP postgraduate training opportunities, development and Fellowships could be the means to creating financial incentives to encourage GP recruitment to such areas.

Electronic prescription service
Dispensing practices and patients in rural areas are entitled to be able to utilise EPS.
The electronic prescription service (EPS) continues to be rolled out in remote areas, and is starting to be utilised in secondary acute and community care. Prescribing practices and pharmacies use EPS regularly. Unfortunately, the software for dispensing practices is not funded and although there are modules available to enable dispensing practices to utilise some of the benefits of EPS, these need to be funded by the practice at considerable expense. The software should be provided, maintained, developed and supported by the NHS.

Prescribing

Shared care arrangements

Collaborative working and good communication are essential when using a shared care arrangement for prescribing drugs. There are good examples of locally developed shared care arrangements, however there are also examples of prescribing where the GP is expected to take on responsibility and monitoring for drugs without resource and potentially outside usual competence or the indicated license. The GMC has clear guidelines about shared care arrangements. The conference of England LMCs has agreed a resolution to develop a national voluntary shared care drug scheme ensuring universal availability for patients, which is fully funded for participating practices. There also needs to be clarity if a provider (NHS or private) chooses to initiate a prescribable drug, but then creates an expectation that the GP will continuing prescribing and monitoring in the absence of resource or acknowledgement of capacity. The BMA advises in such a scenario that the GP can decline to accept such a workload transfer and would encourage a discussion between the LMC and initiating party to embed understanding with clear professional communication to the patient.

Drug Shortages

Drug shortages are an increasing problem for the whole NHS, which particularly adversely impacts upon GPs. There needs to be flexibility for changes within the serious shortage protocols to enable pharmacists to offer generic or equivalent dose alternatives rather than necessitating a new prescription from the GP. GPCE will continue to work with CPE to campaign for greater flexibility for generic prescribing in the event of serious shortage protocols.

Branded Generics

Across England, Integrated Care Boards (ICBs) often encourage the use of branded generics and wholescale switches when a system cost saving can be realised. As a rule, generic prescribing has benefits from the point of view of safety and clarity. However, GPs should always retain the ability to prescribe the medicines they feel are most appropriate for their registered patients. They should not be forced into using particular brands or specified generics unless agreed, and with appropriate resource available. Medicines Optimisation Software (e.g. 'ScriptSwitch' or 'Eclipse') are often purchased at cost by NHS boards and embedded into GP systems to achieve cost savings at scale with little consideration given to the cost of GP time, professional autonomy and patient choice. The budget for prescribing is not insignificant but it is dwarfed by other budget lines across the NHS. The BMA guidance is that a GP can always over-ride or ignore such drug changes which tend to take place within the consultation at the point of prescribing,

Community Pharmacy Services

GPCE recognises that independent pharmacies are struggling in the same way independent GP contracts are struggling. Greater resource is needed into the community provision of services. Pharmacies are now being encouraged to provide additional services which have historically been delivered within the GP setting, for example NHSE's Spring 2024 Pharmacy

First initiative, and some medicines optimisation work. Such initiatives need to be evidence-based, enable patient choice, and attract equitable resource to dispensing practices.

With regard to Pharmacy First, GPCE would flag the importance of this initiative being patient-led, and patients self-referring. Patients presenting to their GP practice to receive treatment for the listed minor illnesses have the choice to be treated within the GP setting. The practice has the right to treat them within the surgery, or signpost them accordingly to a local community pharmacy offering the service. Practices should take care when signposting to advise patients avoid directing patients to one service over another lest they inadvertently fall foul of the regulations by advocating the use of one particular pharmacy, and they should be aware of this risk.