

October 2008

Pharmacy White Paper Dispensing Doctors Consultation

Toolkit for LMCs and all Practices

RESPONSE TO THE PHARMACY WHITE PAPER - TOOLKIT

White Paper Summary

In July 2007, the Minister of State for Public Health, the Rt Hon Dawn Primarolo, MP announced that the Department of Health would publish a pharmacy White Paper.

Pharmacy in England: Building on strengths - delivering the future was published in April 2008 and builds on *A Vision for Pharmacy in the new NHS* launched in July 2003 and *Our health, our care, our say: a new direction for community services* published in January 2006.

The White Paper sets out the Government's programme for a 21st century pharmaceutical service and proposed ways in which pharmacists and their teams can contribute to improving patient care through delivering personalised pharmaceutical services.

The White Paper was developed to align closely with the NHS Next Stage Review led by Lord Darzi and the development of a new primary and community care strategy. It also provided the Government's response to the *Review of NHS pharmaceutical contractual arrangements* commissioned in 2007 and conducted by Anne Galbraith. Her report was published alongside the White Paper. In addition, the White Paper took account of recommendations of the All Party Pharmacy Group' report, *The Future of Pharmacy* published in June 2007. The documents can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083815

The White Paper stated the Government would publish a consultation document which would contain comprehensive on a number of proposals for structural change. The consultation fulfils that commitment and discusses a number of changes and levers which the Department of health believes are needed to transform delivery and to align pharmaceutical services within the wider reform programme in England. The Consultation and Impact Assessment documents can be found at:

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_087324

Contents of the Consultation

Chapter 1 provides background information about pharmacy as part of the vision for delivering *High Quality Care for All* and *Our vision for primary and community care*.

Chapter 2 proposes changes to the current NHS market entry system called 'control of entry' to one based on PCTs' assessments of local needs (Pharmaceutical Needs Assessments) to commission services which promotes choice and competition in the delivery of clinical care and ensures high standards, quality and good patient outcomes for the investment made. It also sets out proposals to enable PCTs to take effective action on quality grounds where contractors are not achieving acceptable performance standards.

Chapter 3 proposes changes to the current arrangements for pharmacies opening at least 100 hours per week. It also proposes introducing 'supplementary lists' for individual pharmacists and discusses compliance with the Safeguarding Vulnerable Groups Act 2006.

Chapter 4 sets out proposals for possible reform of arrangements where doctors provide dispensing services, mainly in rural areas, together with a single regulatory entry system for pharmacies and dispensing doctors.

Chapter 5 discusses market entry proposals for dispensing appliance contractors and a system for appliance contractors comparable to pharmacists' supplementary lists.

Chapter 6 presents proposals for reforming the NHS (Pharmaceutical Services) Regulations 2005 and current legislation relating to Local Pharmaceutical Services.

Chapter 7 sets out the questions arising from these proposals on which the Department welcomes views.

COMMENTS YOU CAN MAKE

The Thrust of the White Paper is to enable pharmacists to utilise their skill and we should welcome this.

The Government wants to shift pharmacy emphasis from dispensing, and provide clinical services through pharmacy at convenient locations and extend pharmacy opening times. The use of Pharmacists' clinical skills would include prescribing, supplying common medicines, become the first port of call for minor ailments "saving GPs one hour per day or 57 million consultations a year" in healthy living centre and provide support for people with Long Term Conditions. Urban LMCs and doctors may have a view on this.

Your free text and answers to the DoH questions should be accurate and supportive of doctor dispensing.

Be supportive of pharmacists and if you have a pharmacist working for some of the time in your surgery, recognise the good work they perform for your patients.

You should encourage your patients to respond individually and not through petitions. Photocopied letters carry little weight. Individual doctors should respond where they have particular issues and practices should definitely respond.

When responding:

- Write free text on each relevant issue
- Answer questions – focus – listed below
- Do not refer to profit but rather a resource put into other services in a rural practice environment
- Emphasise patient services
- Emphasis patient convenience of a one-stop shop
- Emphasise patient choice
- Copy responses to MPs
- Host an MP campaign – MP surgery in your surgery
- Engage parish councils
- Remember a petition counts as ONE response
- Write about the cheapness of doctor dispensing - PPD report
- Disconnect RURAL with DISPENSING
- Put the emphasis on patients.

Whilst we have concentrated on Chapter 2 and 4 you may want to comment on some of the other aspects of the White Paper and the Consultation. Doctors and LMCs in towns and cities may want to comment more fully on the effect any transfer of services to pharmacists may have on their patients and practices.

You should send your comments by Thursday 20th November to:

Gillian Farnfield, Area 453D, Skipton House, 80 London Road, LONDON , SE1 6LH

Chapter 2

Proposes the development of Pharmaceutical Needs Assessments (PNAs) as the single control of entry requirement. PCTs would consider level of access; choice and diversity of providers or services; innovation in service delivery; services available to specific populations; specific health conditions or disease needs; overall longer-term impact of approving new applications. The White Paper paragraph 8.67 says that Commissioning development within PCTs is *not yet at a stage where PCTs can be charged with full contractual responsibilities*. PNAs are variable around the country and many are of poor quality. Many PCTs do not fully include the provision of pharmaceutical services by doctors in rural areas as part of their strategy. There are concerns that without a national standard this can lead to differing rules in neighbouring PCT areas. In view of our preference for “No Change” we suggest that the use of a PNA is not the way forward. LMCs and GPs can develop arguments around their experiences in their respective areas.

Chapter 4

This chapter opens with a statement: *“It has been a long established general precept – one that all Governments have endorsed since the NHS came into being – that doctors prescribe medicines and pharmacists dispense them...”*

You should reject this statement by quoting the current arrangements where some pharmacist, when using their clinical skills at diagnosis, can prescribe treatment including medicines and will be dispensing them. Any supposed conflict of interests for a dispensing doctors can no longer be upheld.

The DoH refers to four major issues:

100 year old legislation

This can be countered with the fact that despite changes in populations, geography etc. the regulations have been updated on numerous occasions, the latest being in 2005

Sustainability of Medical services

The DoH does not like the idea of cross-subsidisation of medical services by dispensing remuneration as this is anti-competitive. The response should be along the lines of there being little competition in rural areas and many services to rural patients are resourced solely through dispensing remuneration streams.

Anomalies

This refers to patients who sit either side of an arbitrary boundary. Whatever rules are set there will always be patients who live on the wrong side of a boundary

Costs

The 5th **Impact Assessment** looks at costs and the savings that might accrue if the control of entry rules were to change.

Many of the assertions made in the Impact assessment are not well researched and do not pass scrutiny. The costs of dispensing are misleading. The NHS Business Authority Prescription Pricing Division Annual report contains accurate information which can be quoted in your response.

- It ignores historical costs when dispensing income was part of pre 2004 GP remuneration
- It ignores clawback and the different rates for pharmacists
- It ignores differences in Pharmacy/GP contracts where payment mechanisms are different.
- It ignores Dispensing Fees are calculated differently between the two professions

FACTS & FIGURES

No of items prescribed per patient per year (to June 2008)

Prescribing Doctors	=	15.63
Dispensing Doctors	=	17.23

There are many reasons why DDs dispense more items than prescribing doctors including the treatment given in additional non-resourced rural service, and that nearly all of the medicines prescribed are dispensed and collected.

The fact that most rural practices use the 28-day repeat interval might be best left out

The average claw-back percentage

Pharmacists average	=	8.67%
Dispensing average	=	11.05%

Drug Costs per patient per annum

	Prescribing	Dispensing
Net Ingredient cost:	£157.10	£149.41
Average discount abatement(%)	8.67%	11.05%
Reimbursement (NHS) cost	£143.48	£132.90
Average fee cost	£27.82	£36.87
Total Cost to NHS (Fees + reimbursement)	£171.30	£169.77

Figures derived from PPD data, year to June 2008 Population figures from NHS IC
 Dispensing patients, 3,510,895; Prescribing patients, 47,031,610 Prepared by DDA

From 1st October 2008 pharmacists received a substantial rise in their remuneration.

Each pharmacy will receive an average extra £3000 per month until March 2009 which is equivalent to a 50.6p uplift per item over the year to March 2009. There is, however, a 16p per item reduction in reimbursement price via Category M.

New Comparisons

Pharmacy	£171.30 > £178.21
Dispensing Doctors No Change	£169.77

There are many features about drug costs that are local and it is worth quoting your local PCT figures for the percentage of generic prescribing in your LMC area or for your practice as this demonstrates the fact that you prescribe cost-effectively and that the PCT monitors this on a continuing basis.

The Impact Assessment implies retrospection but is not clear whether, after implementation, all outlets will be tested against a new criterion or whether new applications by patients to receive their medicines from a doctor will be tested against a new criterion. Any form of retrospection should be rejected and a Grandfather clause should protect all existing outlets in the event of a new test.

The Department of health has identified four options on which they are seeking views.

Option 1 is no change. This has the advantage of maintaining the status quo, does not remove services from patients and does not put any jobs at risk. It does not, however, address the financial issues or the inequities within the current system identified earlier and in particular, whether GP dispensing can be justified when there is a pharmacy in close proximity.

This is the option we would expect you to support

Option 2 is that whilst continuing with current arrangements where GP dispensing applies in controlled localities, the existing specific distance criteria would be removed. This would allow PCTs to determine the rural localities where GP dispensing is appropriate on the basis of their PNA. This option could address the current anomalies of a rigid national scheme and empowers local communities to make decisions appropriate to their needs. It aligns with the longer-term strategic direction for commissioning and pharmaceutical services generally, based on PNAs.

PNAs as proposed offer no uniformity, can be variable and allow the PCT opportunities to target provide and should not be supported and may negate any existing Reserved Location status.

Option 3 would mean that, instead of the distance between the patient's home and the pharmacy, the determining factor should be a distance between the dispensing surgery and the nearest community pharmacy. Such a distance could be put at less than the current 1.6 km, for example, at 500 m or at 1000 m. This removes the anomaly of a doctor dispensing to some of his/her patients where there is a community pharmacist in close proximity and also removes the question of a practice having dispensing and non-dispensing patients. Such a 'cliff edge' effect is less pronounced than under the current arrangements although there may still be such cut-offs where there are nearby practice boundaries.

The loss of the one mile (1.6km) rules would probably negate the Reserved Location status and would cause severe disruption to patient services and may destroy inter-professional relationships. This should not be supported.

Option 4 is a variation of Option 3. It would mean that a GP would not dispense where there is a pharmacy within 500 m or 1000 m of the GP practice and a second pharmacy within 1500 m. Those who are permitted to dispense may do so to all their registered patients regardless of the distance between their home and the surgery or pharmacy. This option maintains an element of choice for patients when having their drugs dispensed and has a less pronounced effect on GP dispensing.

The loss of the one mile (1.6km) rule would probably negate the Reserved Location status and would cause severe disruption to patient services and may destroy professional relationships. This should not be supported.

OTC Sales

The chapter also proposes the sale of OTCs by dispensing doctors. This is not a major issue but there are some questions posed by the DoH to focus on this issue.

QUESTIONS TO ANSWER

The Department of Health proposes a number of questions to focus your responses. We suggest that you write in free text to focus on your own local issues but that you also answer the questions.

QUESTIONS IN CHAPTER 2

The Department proposes amending legislation to replace the current market entry system based on the “necessary and expedient” test with one based on a PCT’s assessment of local pharmaceutical needs and to introduce specific factors which a PCT would take into account in determining applications

Do you agree the current market entry system should be changed to one based on pharmaceutical needs assessments (PNAs)?

What safeguards may be appropriate to ensure transparent, fair and unbiased consideration of applications?

Do you agree that specific additional factors, as identified in this Chapter, should also be introduced to help PCTs determine applications?

Should decisions be appealable and, if so, to whom?

Do you agree exceptions to this new system may be necessary and, if so what might these exceptions be? If introduced, do you agree such an approach should be piloted and evaluated before introduction?

QUESTIONS IN CHAPTER 4

The Department has identified four possible options to reform the current arrangements for dispensing by doctors

Is the Department right in believing that there are inequities and anomalies within the current procedures under which patients can obtain their medicines and appliances directly from their surgery rather than from a community pharmacist?

Have you any personal experience of any such inequities and anomalies? If so, please briefly set them out.

Do you believe that having a local choice between two or more local dispensers when having a prescription dispensed is important to you? Could you quantify how important this is for you on a scale of 1-5 where 1 is exceptionally important and 5 is of no importance?

Is it right for the Department to publish a national set of rules setting out when a doctor can provide dispensing services or should the local NHS, for example your PCT, consulting with others, have more say?

Do you agree that the four options set out in this consultation document relating to dispensing by GPs are appropriate options for consideration? Are there others that should be considered?

If you have a preference between Options 1-4, please indicate which is your preferred option and why.

If there were to be change, what issues do you believe the Department should take into account when implementing any new system?

Are there other factors to take into account – for example, how well do these options or your preferred option link to the proposals below for a common regulatory route for all applications?

The Department proposes to amend the 2005 regulations (and associated primary legislation) to introduce a single regulatory route to authorise dispensing by doctors in rural areas.

Do you agree:

the proposal to align the regulatory route for dispensing doctor applications with those of pharmacies and appliance contractors?

dispensing by doctors should, as now, apply to those patients who live in designated rural areas?

the approval of doctors' dispensing premises should continue?

the 'serious difficulty' rule should be retained to enable a PCT to authorise dispensing for any patient who has serious difficulty getting to a pharmacy?

Are there other factors which need to be taken into consideration?

The department proposes to allow, where there is no convenient alternative, dispensing doctors to supply over the counter medicines to all of their patients, subject to the MHRAs review and forthcoming informal consultation on the current medicines legislation.

Do you believe that it would be beneficial for patients and consumers if dispensing doctors were able to sell general sale list (GSL) medicines to their patients where there is no convenient alternative?

Do you believe that it would be beneficial for patients and consumers if dispensing doctors were able to sell pharmacy (P) medicines to their patients where there is no convenient alternative? How might the term 'convenient alternative' best be defined? For example, should a distance limit of, say 500 m, be set, or should this be left to local determination?

If dispensing doctors were to sell P medicines, do you agree there should be safety provisions regarding such supply - for example, similar or equivalent to those that govern the sale and supply of P medicines through pharmacies? Are there any risks not identified here?

You should send your comments by Thursday 20th November to:

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