A DEEP DIVE INTO DISPENSING GP PRACTICES IN SCOTLAND v4.0

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Contents

ABBREVIATIONS

Abbreviations used in this paper:

BMA	British Medical Association
DDA	Dispensing Doctors Association
DPDP	Digital Prescribing and Dispensing Pathways Programme
GMS	General Medical Services
GMS Contract	NHS (General Medical Services Contracts) (Scotland) Regulations 2018
GP	General Practitioner
GPC	General Pharmaceutical Council
HSCP	Health and Social Care Partnership
PRISMS	Prescribing Information System for Scotland
RGPAS	Rural GP Association of Scotland
RRHEAL	Remote and Rural Healthcare Educational Alliance
SFE	Statement of Financial Entitlement
SGPC	Scottish GP Committee

INTRODUCTION

Dispensing GP practices provide a vital role in rural communities across Scotland, ensuring that patients have access to prescribed medication even when they live some distance from a Community Pharmacy. The role of the rural General Practitioner (GP) and their small team (managers, receptionists, dispensers and general practice nurses) provide a high quality, safe and sustainable service that is an important element to the sustainability of rural communities and is highly valued by patients.

The Scottish Government recognises the importance of this service and that there may be areas where rural dispensing GP practices could benefit from some additional support. This report hopes to identify the main issues affecting these dispensing GP practices and makes a number of recommendations as to what could be done to provide additional support to them.

The scope of this document is dispensing GP practices and processes. It does not cover other areas or issues affecting rural GP practices that have been covered by Professor Sir Lewis Ritchie's '*Shaping the Future Together*[1]' Report, published in January 2020.

In 2018 the Scottish Government and the Scottish GP Committee of the BMA agreed "*The 2018 General Medical Services Contract in Scotland*"[2]. This document set out the policy for the future direction of travel for general practice and stated that:

> *"primary care in Scotland [is] on a journey towards reducing unsustainable workload in general practice, through the expansion of multidisciplinary teams of health professionals"*[3].

With regard to dispensing GP practices, it set out that:

> "*The current arrangements for dispensing in Scotland will not change under the proposed new contract. As part of the preparation for a Phase 2, we will establish a* ***short-life working group*** *to consider the current dispensing arrangements and look for any mutually beneficial improvements. Relevant interest groups will be consulted to ensure their views are incorporated."*

To support the implementation of the GP Contract in remote and rural areas, Sir Lewis Ritchie's Remote and Rural Working Group was established, with the first meeting in August 2018, in Inverness.

The Scottish Government also established a sub-group of the Remote and Rural Working Group, the Dispensing Short Life Working Group[4] to:

a. "*Consider the implications of the implementation of Phase One of the 2018 GMS Contract on Dispensing Practices including the role of pharmacists and pharmacy technicians. In particular it will consider the implementation of Pharmacotherapy services in Dispensing Practices (DPs)."*
b. "*Identify opportunities to develop and support dispensing practices (including 2C practices) in the future*."

[1] https://www.gov.scot/publications/shaping-future-together-report-remote-rural-general-practice-working-group/
[2] https://www.gov.scot/publications/gms-contract-scotland/
[3] https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/2021-update-to-2018-scottish-gms-contract#:~:text=The%202018%20Scottish%20GMS%20Contract%20embarked%20primary%20care%20in%20Scotland,multidisciplinary%20teams%20of%20health%20professionals.
[4] https://www.gov.scot/groups/gp-dispensing-group/

Chaired by Fiona Duff, Senior Advisor to Scottish Government's Primary Care Directorate (seconded from NHS Highland), the dispensing group membership comprises representatives from a range of rural and island Health Boards and Integration Authorities, as well as representative bodies such as the Dispensing Doctors Association (DDA), Rural GP Association (RGPAS) and the Scottish General Practitioners Committee of the BMA. The group members (see Appendix 1) met several times during 2018 and 2019. Due to the COVID-19 pandemic the group has not met for some time and requires a review of membership. Once that has been completed, the Working Group will reconvene to consider this report and its recommendations.

In January 2020, Sir Lewis Ritchie published a comprehensive report, "*Shaping the future together*"[5] with recommendations aimed at supporting a sustainable rural general practice. The recommendations were agreed by the Rural Group in January 2020, endorsed by the Cabinet Secretary for Health and Social Care and by the Scottish General Practitioners Committee of the BMA. In the report Sir Lewis recommended that the dispensing group should continue to develop a "*package of support"* that would "*protect and enhance the sustainability of Dispensing [GP] Practices*". In addressing this, consideration should be given to the additional work, remuneration and the risk to dispensing GP practice in Scotland.

A series of support activities have been delivered by the dispensing group since its inception (such as staff training, IT provision and patient safety initiatives[6],[7]) that dispensing GP practices have found to be of invaluable assistance.

Dispensing GP practices, Health Boards and Health and Social Care Partnerships (HSCPs) have highlighted a number of issues that can adversely affect their services (and long-term sustainability), and made suggestions on how they may be addressed. To explore this in more detail, the Dispensing Group commissioned NHS National Services Scotland (NSS) to carry out a "deep dive" into dispensing GP practices. The key aims of this engagement and research activity is to explore these issues raised through the Group and prepare a report to inform the next steps in support of dispensing GP practices.

Due to the restrictions associated with the COVID-19 pandemic it was not possible to visit any of the dispensing GP practices interviewed for this project. However, the report provides as much detail and information as was possible through remote engagement. It also provides an overview of dispensing GP practices in the context of the services they deliver to patients within remote and rural Scotland.

[5] https://www.gov.scot/binaries/content/documents/govscot/publications/progress-report/2020/01/shaping-future-together-report-remote-rural-general-practice-working-group/documents/shaping-future-together-report-remote-rural-general-practice-working-group/shaping-future-together-report-remote-rural-general-practice-working-group/govscot%3Adocument/shaping-future-together-report-remote-rural-general-practice-working-group.pdf
[6] https://www.sehd.scot.nhs.uk/pca/PCA2021(M)01.pdf: NHS Medicines Delivery Service
[7] https://www.sehd.scot.nhs.uk/details.asp?PublicationID=6425: Funding for Dispensing GP Practices

BACKGROUND

Health and social care, including the provision of General Medical Services and the provision of medicines in remote rural and very remote rural[8] communities have always required careful consideration and planning due to their isolation and geography. Their unique needs have been well documented for decades. Initially highlighted by the 1912 Dewar Report[9], the establishment of the Highlands and Islands Medical Service was a first step to satisfy those needs; being the first state funded and centrally planned health service delivering health care thirty years before the NHS was created.

According to the National Records of Scotland[10] "*communities in rural and island areas of Scotland are ageing at a faster rate than those in urban areas*" as the older population moves to rural areas to retire and younger people move to urban environs to pursue higher education and employment. The older population often bring with them an expectation of access to services that they may have experienced when living in more urban areas.

Referring to the Scottish Urban Rural Classifications[11], the National Statistics for Scotland[12] reported that, although rural Scotland accounts for 17% of the total population, it covers 98% of the land mass. The key messages from the report include a 5.3% increase in the population in rural areas that is driven by "*an increase in accessible rural areas, and inward migration*." This is compared to a 2.1% increase across the rest of Scotland. However, proportionately, the number of people in remote communities continues to be significantly smaller than in rural areas.

These trends suggest that the ageing population in rural Scotland is likely to continue to grow at a faster rate than those in urban areas. They also suggest that consideration needs to be given to, not only the current, but also the future health and care provision within remote Scotland. This should perhaps be taken from the perspective that urban solutions rarely translate to a rural setting, but solutions to rural problems often translate the other way[13].

> "*If we want to ensure fair access to care in rural populations, tailored to their unique circumstances, we need plans to tackle these issues. And we have to start by recognising that their needs are the same but different."*
>
> **Source:** David Oliver, consultant in geriatrics and acute general medicine

In addition to ensuring access to person-centric primary care services from their GPs, Health Boards have the responsibility to ensure their patients, regardless of their geographic location, have access to pharmacological services[14]. Should Health Boards identify locations where patients would have serious difficulty in obtaining NHS dispensed medicines and appliances from an independent Community Pharmacy then, under the terms of the National Health Service (Scotland) Act 1978[15], Health Boards must require a General Practice to dispense NHS medicines to patients on their practice lists.

This means that in some remote and rural areas of Scotland, dispensing services are provided by dispensing GP practices. Where a GP provides (dispenses) medication prescribed to a patient on their practice list from the practice's own stock, so the patient need not go to a Community Pharmacy[16] some distance away from the patient, this is known as a **dispensing GP practice**.

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[8] https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/pages/2/#:~:text=Very%20Remote%20Rural%20Areas,3%2C000%20people%20to%20be%20rural.
[9] https://www.hebrideanconnections.com/stories-reports-and-traditions/61879
[10] https://www.nrscotland.gov.uk/files//statistics/population-estimates/sape-19/sape-19-publication.pdf
[11] https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/pages/2/
[12] https://www.gov.scot/publications/rural-scotland-key-facts-2018/pages/2/
[13] https://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/An_Approach_to_Building_Sustainability_of_Health_and_Care_Services_in_Remote_and_Rural_Areas_FINAL_redacted.pdf
[14] https://www.gov.scot/policies/primary-care-services/pharmacy/
[15] https://www.legislation.gov.uk/ukpga/1978/29/contents
[16] https://app.croneri.co.uk/topics/dispensing-practices/quickfacts#:~:text=In%20a%20dispensing%20practice%2C%20the,not%20go%20to%20a%20chemist.

17C and 17J practices

There are different types of dispensing GP practices in Scotland, the majority fall within section 17C and section 17J categories where:

- A **section 17C** practice is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances.

- A **section 17J** or General Medical Services practice is one that has a standard, nationally negotiated contract.

There is normally no pharmacy or pharmacist involvement in these practices and the service is provided by the GP and their team of staff (Practice Manager, Dispensers, Receptionists, General Practice Nurses etc.). The GP and their team must ensure that the practice has the appropriate stock available, and that it is stored, prescribed and dispensed safely and appropriately.

As there is no pharmacy within the practice, the ability to purchase 'over the counter' medicine is restricted. The dispensing GP practice will therefore need to prescribe and dispense the items that otherwise would have been bought.

2C Practices

There are also 2C practices that, in general terms most likely mean that the practice is run by their respective NHS Board, as opposed to being run by GPs and / or other partners, as is the case for practices with 17C or 17J contract types.

The organisation of 2C practices differs from Board to Board. For example, there is a blended model in operation across Orkney and Shetland where all prescriptions are managed by a dedicated Community Pharmacy.

However, a blended approach by others allows repeat prescriptions to be arranged by a Community Pharmacy and acute medication prescribed by the 2C practice on the day. This arrangement allows cover for citizens to acquire medicine during the practice contracted hours and the Out of Hours period.

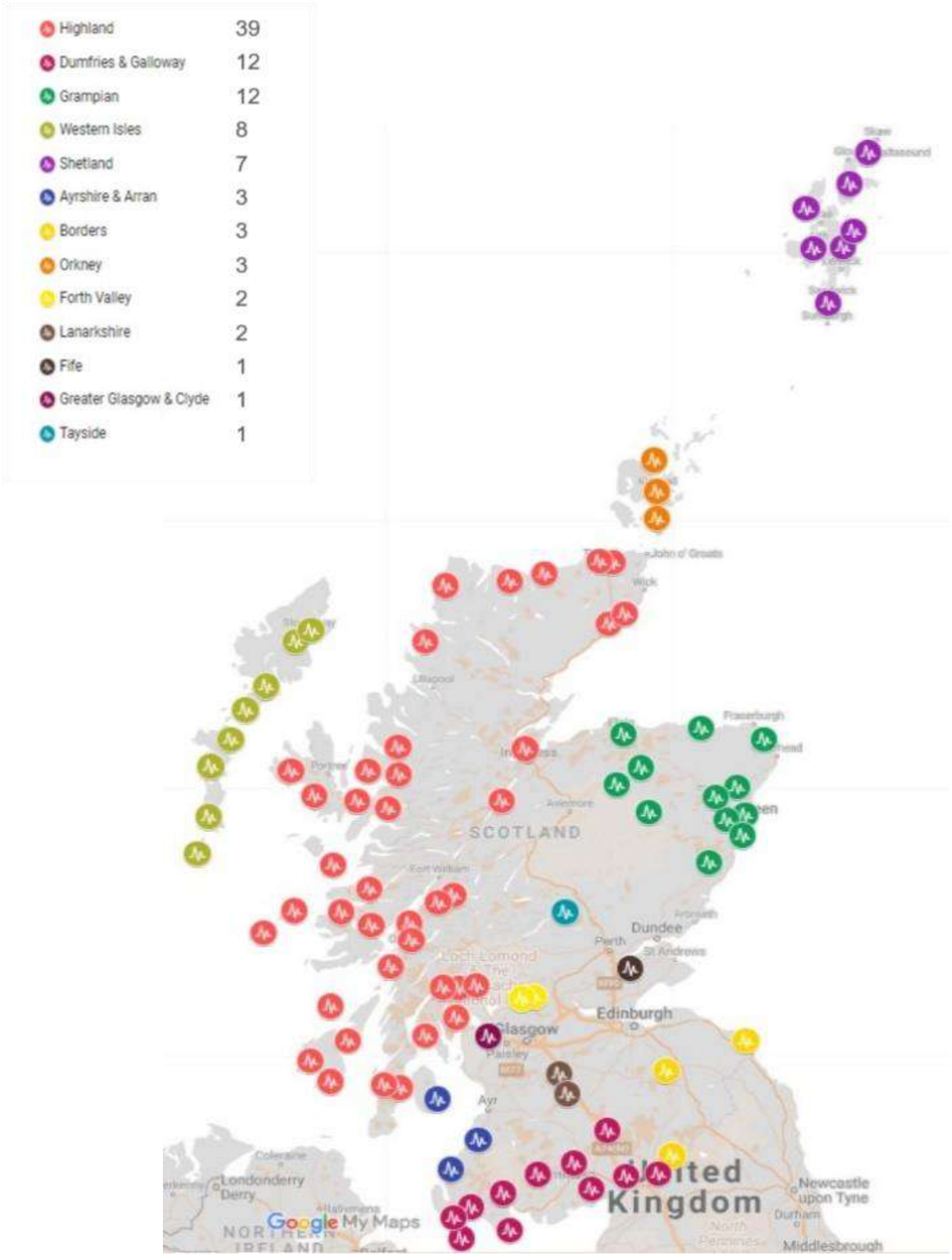
Dispensary

The picture below is a typical dispensary in a dispensing GP practice.

The layout and design of a dispensary will vary from practice to practice depending on its size, location, etc. but all have facilities to ensure safe and secure storage of medicines in common.

Photo: Courtesy of Dr Kate Dawson, Benbecula, Western Isles

As of 1 October 2020, there were 94 Dispensing GP practices operating within 13 Health Boards[17]. The list of main practice sites, their list size and contractual status is captured within Appendix 2. Some dispensing GP practices work across multiple sites or branch surgeries that are not included within the list. Therefore, the total number of sites related to dispensing GP practice is greater than the 94 shown in the diagram below.



[17] https://www.isdscotland.org/Health-Topics/General-Practice/GPs-and-Other-Practice-Workforce/Glossary.asp#:~:text=2C%20practice%3A%20In%20general%20terms,17C%20or%2017J%20contract%20types).

Dispensing GP practices comprise approximately 10% of the total number of GP practices[18] in Scotland and cover approximately 3% of the total number of patients.

The dispensing GP practice is the first port of call regarding general medical and dispensing services for the local community. The GP Contract covers that service from Monday to Friday, 8am to 6.30pm (locally this may be 6pm in some areas). If required urgently, out with that period of time, medication is provided by the Out of Hours service. It is noted that in some remote practices the Out of Hours service is provided by the dispensing GP practice itself and thus in these cases the practice provides medication at all times.

As the NHS (Pharmaceutical Services) (Scotland) Regulations 2009[19] apply to Community Pharmacy and not General Practice, there are no references made to dispensing GP practices, nor are there currently any Scottish national guidelines or standards setting out how dispensing GP practices should operate their dispensary. There is mention of dispensing within the GMS Regulations[20] and Statement of Financial Entitlement[21] (SFE) which is updated annually by Scottish Government following negotiations with the Scottish GP Committee (SGPC). There is however an expectation that the practice will meet security, storage, cold chain, checking of dispensed medicines, etc. in no lesser way than Community Pharmacies.

[18] https://www.isdscotland.org/Health-topics/General-practice/
[19] https://www.cps.scot/media/1721/07012013the-nhs-pharmaceutical-services-scotland-regulations-2009.pdf
[20] https://www.legislation.gov.uk/uksi/2021/331/contents/made
[21] https://www.sehd.scot.nhs.uk/publications/GMS_Statement_of_Financial_Entitlements_2020-21.pdf

CHALLENGES/ ISSUES

According to the Scottish School of Primary Care "*Remote and rural General Practice in Scotland: descriptors and challenges*"[22]

> *"Some of the common themes in the approaches to addressing the challenges facing rural doctors that are contributing to chronic workforce shortages relate to taking a systematic approach to recognising, measuring and developing planning and policies which reflect the distinctions of practice in rural and remote locations.*
>
> *This is described as 'rural-proofing', and is recognised as an important concept in health and social policy in the UK … As well as a systematic approach, contextualising solutions to local realities and situations"*

As a result of feedback from dispensing GP practices, DDA, Rural GP Association of Scotland (RGPAS), SGPC, Health Boards, HSCPs, through wider engagement and research, there are a number of challenges facing dispensing GP practices in Scotland.

The key challenges have been collated into six themes.

1. COVID-19
2. GMS Contract
3. Finance
4. Data
5. Dispensing service
6. IT

1. COVID19

General Practices, including dispensing GP practices, remained open and provided services to their patients throughout the pandemic. In following infection control, social distancing and other Public Health and Scottish Government Guidance, practices had to adapt and introduce new systems and processes quickly and flexibly to allow patients to access services safely.

Dispensing GP practices had additional issues to consider. Depending upon the type of practice, examples are:

- How to continue to provide a safe and effective dispensing service including safe and reliable provision and in some cases delivery of medication to patients
- Impact on cash flow due to changes in prescribing and dispensing frequency
- Staff wellbeing and resilience especially in small teams (including the impact of staff illness and self-isolating).

[22] http://www.sspc.ac.uk/media/Media_683800_smxx.pdf

The Scottish Government introduced several initiatives to support GP practices through the pandemic. These included arrangements to ensure no financial detriment because of the pandemic and a specific initiative for dispensing GP practices to support the delivery of dispensed medication to patients who were shielding (in line with a similar scheme for Community Pharmacy). A new scheme was also introduced to allow dispensing GP practices to distribute lateral flow test kits to patients, again, in line with a similar scheme for Community Pharmacies.

The Scottish Government, working with NHS Education for Scotland and Healthcare Improvement Scotland, provided GP practices across Scotland with guidance and support throughout the pandemic. This included guidance on developing business continuity plans however there was no specific guidance for dispensing GP practices and the specific business continuity challenges they faced and could face in the future. The Scottish Government also launched several wellbeing resources including a Practitioner Health Service which is available to all GP practices.

Recommendation 1
A business continuity toolkit and related resources, specifically aimed at supporting dispensing GP practices, should be developed.

2. GMS CONTRACT

In April 2018, implementation of Phase One of the GP Contract started, alongside changes to the regulations for GP practices in Scotland. The supporting Memorandum of Understanding[23] between Scottish Government, the Scottish General Practitioners Committee of the BMA, Integration Authorities and Health Boards set out guidance as to how the changes would be implemented. The Memorandum of Understanding Two[24] was published by Scottish Government in August 2021 and again reiterated the requirement for all HSCPs to provide Pharmacotherapy services to practices by April 2022.

One key work stream was to deliver an "*integrated pharmacotherapy service"* a three-level approach designed to:

"allow more pharmacists and pharmacy technicians to work in general practice, reducing GP workload and improving patient care" [25]

All dispensing GP practices receive pharmacy input concerning prescribing and other related information. This can create inconsistency within the practice, for example medicine reconciliation is done by a pharmacist when available but defaults to a dispensing doctor at other times.

Pharmacotherapy services are being rolled out to rural dispensing GP practices in different ways and at varying pace depending on the HSCP Primary Care Improvement Plan. For example, Dumfries and Galloway developed a hub and spoke model with pharmacists, pharmacy technicians and pharmacy support workers working remotely and including support to some dispensing GP practices.

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[23] https://www.gov.scot/binaries/content/documents/govscot/publications/correspondence/2017/11/delivering-the-new-gms-contract-in-scotland-memorandum-of-understanding/documents/delivering-gms-contract-in-scotland---memorandum-of-understanding/delivering-gms-contract-in-scotland---memorandum-of-understanding/govscot%3Adocument/Delivering%2BGMS%2Bcontract%2Bin%2BScotland%2B-%2BMemorandum%2Bof%2Bunderstanding.pdf

[24] https://www.sehd.scot.nhs.uk/publications/Memorandum_of_Understanding%202-GMS_Contract_Implementation_for_PC_Improvement%2030_July_2021.pdf

[25] https://pharmaceutical-journal.com/article/news/new-pharmacotherapy-service-to-be-set-up-as-part-of-scottish-gp-contract#:~:text=The%20pharmacotherapy%20service%20would%20be,GP%20as%20expert%20medical%20generalists.&text=and%20heart%20failure.-,The%20pharmacotherapy%20service%20would%20be%20one%20part%20of%20the%20new,GP%20as%20expert%20medical%20generalists%E2%80%9D.

Other rural boards, such as Highland, Orkney, Shetland and Western Isles successfully rolled out pharmacotherapy to dispensing GP practices. The pace was varied due to the availability of trained staff, including pharmacists and pharmacy technicians. The role these staff undertake within dispensing GP practices may be different to the one they are carrying out in more urban practices, depending on the model adopted locally, but their input is greatly valued by the practices.

Alongside the development of the pharmacotherapy service envisaged by the new GP contract, are commitments outlined in Achieving Excellence in Pharmaceutical Care[26]. These aim to transform the role of pharmacy across all areas of pharmacy practice, to increase capacity, to offer the best person-centred care and "*to and help sustain service in remote and rural communities, including dispensing doctor practices".*

Recommendation 2
As set out in the Memorandum of Understanding Two, Scottish Government, HSCPs and Health Boards continue to implement the roll out of Pharmacotherapy services to all GP practices, including dispensing GP practices

GMS Contract Phase Two

Subject to further consultation and negotiations between the Scottish Government and the Scottish General Practitioners Committee of the BMA, Phase Two of the 2018 GP contract offer will see the introduction of direct-reimbursement of agreed expenses (for staff and other practice expenses) and "*introduce an income range comparable to that of consultant*", from The 2018 General Medical Service Contract in Scotland document.[27]

The 2018 GP contract offer explains that direct reimbursement for staff will include costs associated with staff sickness, maternity, paternity and adoption leave, staff cover for long-term sickness and maternity leave. It will identify the resources needed within each practice to meet patient demand, taking into account the workload generated by a growing and ageing population to ensure the practice provision reflects patient demand.

The 2018 GP contract offer[28] stated that:

> "*remote GP practices will, as they do now, continue to provide a broader range of services more appropriate to remote settings*" and that "*rural GP practices have, on average, higher expenses per patient than urban ones … diseconomies of scale of small GP practices and the costs of dispensing or having one or more site / branch surgeries … these differences will need to be addressed by proposals for Phase 2."*

GP practices, as independent contractors, employ their own practice management, administrative and nursing staff including dispensing staff, with the GP partners drawing any profits from the business after all staff costs, other running costs and expenses, including dispensing drug stock, have been paid and all GMS and dispensing practice income has been received via Practitioner Services.

Income less Expenditure = GP partner income (profit)

[26] https://www.gov.scot/publications/achieving-excellence-pharmaceutical-care-strategy-scotland/
[27] https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/00527530-pdf/00527530-pdf/govscot%3Adocument/00527530.pdf
[28] https://www.gov.scot/publications/gms-contract-scotland/pages/5/

Consideration will need to be given by the Phase 2 negotiators to the implications of reimbursing staff costs and other expenses for dispensing GP practices. Many practice staff involved in the dispensing process have dual roles as receptionists, medical secretaries and dispensers and splitting out staff time and expenses for dispensing and non-dispensing work may be challenging. Understanding the additional costs associated with running a dispensing practice, including those practices who provide dispensing over more than one site, and the level of profit that practices can make will need to be understood as part of any negotiations between Scottish General Practitioners Committee of the BMA and the Scottish Government.

Recommendation 3
To help to inform negotiations around Phase 2 analysis of dispensing GP practice Income and Expenditure should be progressed to understand the financial implications of dispensing

3. FINANCE

There are two aspects of finance that dispensing GP practices need to consider,

- Expenditure - which includes the cost of purchasing drugs, staff costs and other overheads (including premises, utilities etc.).
- Revenue - includes several different reimbursements and discounts

Dispensing GP practices are responsible for sourcing and purchasing the medicines that they dispense on a day-to-day basis from pharmaceutical suppliers who deliver drugs to practices on a regular basis (daily, twice weekly or less frequently depending on location) before being reimbursed for the medication they have prescribed. In the financial year 2019/20, £22.9 million[29] was paid to dispensing GP practices for dispensing services.

Expenditure

Procurement of medicine

Dispensing GP practices purchase prescription medication and drugs from authorised drug wholesalers. The wholesaler invoice price is the payment made by them to the wholesaler for the actual drug purchased.

The quantity of drugs purchased depends upon each dispensing GP practice's requirements; they need to consider the size of their patient list, frequency of delivery, etc. Due to the size of their operations, Community Pharmacies can achieve bulk discounts for drugs purchased from wholesalers. The smaller dispensing GP practices cannot.

Dispensing GP practices also tend to be affected by low volume surcharges applied when quantities of drugs ordered are lower than a threshold. These surcharges can incur significant additional costs to a practice.

Although dispensing GP practices do not normally hold a large stock of medicine, this practice has changed in some areas due to the impact of the pandemic, with a potential impact on practices cash flow as they need to purchase more stock before they prescribe it and therefore receive reimbursement.

[29] https://beta.isdscotland.org/find-publications-and-data/healthcare-resources/finance/nhs-payments-to-general-practice/

VAT

In accordance with HMRC rules, dispensing GP practices are not required to be VAT registered in the same way as non-dispensing GP practices whose turnover may be above the normal VAT registration threshold. The majority of NHS income is exempt from VAT.

However, dispensing GP practices that are not VAT registered will be unable to recover VAT paid to wholesalers on the purchase of the drugs they dispense.

The following list from the DDA Dispensing Guidance 2019[30], shows that the management of VAT within a dispensing GP practice is complex and can lead to confusion and payment anomalies.

For example:

- VAT paid on NHS dispensed prescriptions will be reimbursed through HMRCs VAT system
- Items classed as personally administered by the NHS pricing authority are VAT-exempt and reimbursed via VAT allowance which is automatically paid monthly.
- For VAT purposes, any item personally administered or applied to a patient by the GP, or his staff, is VAT exempt.

GPs and Practice Managers in dispensing GP practices may lack the knowledge and experience on how to manage VAT and rely on professional advice available via their practice accountants. This adds an additional cost to dispensing GP practice expenses which must be met from practice income, on top of routine accountant costs.

Recommendation 4
Further investigate the impact of differences in SFE and HMRC regulations on Dispensing GP practices. Additional support and training to GPs and Practice Managers on how to manage financial processes including VAT should be considered

Revenue

In principle, the generic profit margin achieved for medication and drugs procurement is relatively simple to calculate. For example, should the cost of a drug purchased from a wholesaler cost £0.50, and the drug tariff price is £0.75, then there would be a £0.25 profit. However, as the wholesaler price is determined by market forces and the drug tariff price varies over the course of a month, the profit margin can become difficult to calculate.

Any profit made is used by dispensing GP practices to pay their overhead costs and operating expenses associated with dispensing such as staff costs, premises expenses and other overheads. However, due to the changing rates within the drug tariff, the application of various discounts and allowances, determining dispensing income in a timely manner is reportedly difficult for dispensing GP practices which can sometimes result in issues with the practice cash flow.

Drug Tariff

Clinicians who prescribe any medication will routinely use their Health Board drug formularies and the British National Formulary[31] in order to understand what the most appropriate and cost-effective drug is to prescribe.

[30] https://www.dispensingdoctor.org/wp-content/uploads/2018/10/DDA-Guidance-Booklet_2019_WEB.pdf
[31] https://bnf.nice.org.uk/

The drugs that can be dispensed and the actual amount they will be reimbursed for dispensing a medication is derived from the Scottish Drug Tariff[32]. The drug tariff is the definitive reference paper for all prescribers and dispensers in Scotland, setting out the rates payable for the provision of pharmaceutical services and the way in which reimbursement is calculated for generic and proprietary products, and approved appliances. Within Part 7 payments (generics) are determined to target a specific profit figure for Community Pharmacies, however, the needs of the smaller dispensing GP practices are not taken into consideration in this context.

Due to market fluctuations the drug tariff is updated regularly and this can be up to three or four times during the period of a month. The drug tariff provides frequent updates with 'change' information over the course of each month, each depicting whether the reimbursement amount for the drugs purchased has gone up or down since the previous update. Due to the frequency of updates, it can be challenging for dispensing GP practices to keep track of and monitor their reimbursement for drugs purchased.

Name	Form	Strength	Quantity	Price (p)	Change
Isoniazid Oral SF	Soln	50mg/5ml	500ml	**5097**	↑
Ketamine Oral	Soln	50mg/5ml	300ml	**7016**	↓
Lorazepam Oral	Susp	1mg/5ml	100ml	**7107**	↑
Lorazepam Oral	Susp	500mcg/5ml	100ml	**5551**	↑
Midazolam Buccal prefilled syringe SF	Soln	2.5mg/0.25ml	4	13800	

Source: Scottish Drug Tariff: An extract from part 7S

Community Pharmacy Scotland[33] provides drug tariff change information on their website. The website allows only community pharmacies to report issues experienced obtaining medicines and to sign up to receive information concerning shortages.

Recommendation 5

The impact of changes to drug tariff on dispensing GP practices needs to be better understood and communicated to dispensing GP practices and how Dispensing GP practices can be better involved in the drug tariff process should also be considered

Reimbursement and payment

The drug tariff price is the amount Practitioner Services reimburses to dispensing GP practices for generic prescription medication that has been prescribed and dispensed.

Within the Statement of Financial Entitlements[34], Section 14, see Appendix 3, relates to the payments to be made to dispensing GP practices under a general medical services contract.

The Core Business Rules for Reimbursement[35], stipulate how payments are calculated.

The end-to-end business process that enables reimbursement and payment of prescription payments to dispensing contractors is complex and differs from that of Community Pharmacy.

Within Community Pharmacies, dispensed prescriptions are sent electronically to Practitioner Services, with the paper prescription sent separately. Practitioner Services scan the paper

[32] https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff/
[33] https://www.cps.scot/nhs-services/remuneration/drug-tariff/adjusted-prices/
[34] https://www.sehd.scot.nhs.uk/publications/GMS_Statement_of_Financial_Entitlements_2020-21.pdf
[35] https://www.isdscotland.org/health-topics/prescribing-and-medicines/scottish-drug-tariff/Docs/November-2015/2015-11-SDT-Part14.pdf

prescriptions, merge the digital data with the paper data they receive, checking for accuracy, and manage any anomalies that may occur. This then allows payment to the Community Pharmacy to be made. This system is currently not available to dispensing GP practices who have to follow a monthly paper-based process.

For dispensing GP practices the cyclical process looks like this:

End of month one / Beginning of month two

Paper prescriptions are taken to the Post Office, or sent via a courier, to Practitioner Services for scanning and validation.

Month two

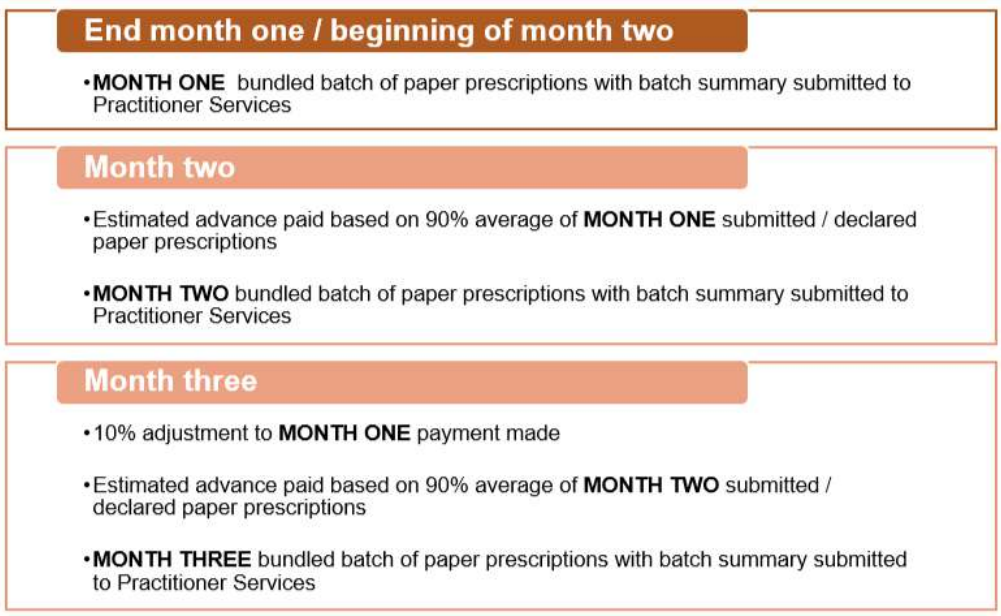
An estimate advanced payment for the month one submission is calculated for the dispensing GP practice based on an average of 90% of the total declared items. Through engagement with Practitioner Services, it is possible to vary the 90% average across the financial year to help contractors with any cash flow pressures.

The estimated advanced payment amount is paid to the dispensing GP practice.

Month three

For the remaining 10% of the month one submission, an adjustment is made based upon the actual costs per item. This can result in either an additional payment or a reduction in payment being made to the dispensing GP practice.

The additional payment or reduction is considered with the average cost per item when estimating the advance payment for the next batch of paper prescriptions. This is reflected in the payment schedule.



Therefore, the full payment for the “month one” submission is made circa 45-50 days if not longer after receipt by Practitioner Services.

This cyclical process of continuous payments, comprising ongoing advance payments plus recovery of previous advances, makes it very difficult for a dispensing GP practice to forecast or analyse their payments, which can have an adverse impact on the cash flow within a small dispensing GP practice.

Recommendation 6

An electronic process for dispensing GP practices, facilitating clear payment details, similar to that in place for Community Pharmacies, should be developed and implemented as a priority

Discounts and entitlements

There are several discounts and entitlements applicable to dispensing GP practices that are fully explained within the GMS Statement of Financial Entitlements[36] Section 14.

1. Special payment

Where a dispensing GP practice has had to procure drugs, appliances, etc, at a price more than the amount that would be reimbursed through the drug tariff (referred to as the basic price), a special payment is made by Practitioner Services. Full details are in Appendix 3. The appropriate level of special payment is:

Where on average the price paid (excluding VAT) is:	Special payment
In excess of 5% and up to 10% over basic price	5% over basic price
In excess of 10% and up to 15% over basic price	10% over basic price
In excess of 15% and up to 20% over basic price	15% over basic price
In excess of 20% over basic price	20% over basic price

Special payments incur a VAT allowance that is calculated on the basic price plus the special payment.

2. Rate of discount

The rate of discount per prescription is calculated on the principle that the greater the number of prescriptions submitted to Practitioner Services for pricing, the greater the percentage rate of discount will be applied.

The table below is an excerpt from Schedule 1: Discount scale. Full details are captured within Appendix 3.

Total basic price of all prescriptions submitted for pricing by Practitioner / Practice in month	Rate of discount to be applied to Basic Practice %
1-1000	0.00
1001-1125	0.08
1126-1250	0.15
1251-1375	0.21

3. Dispensing fees

Dispensing Fees paid to a dispensing GP practice are based upon volume, for example the number of drugs dispensed per prescription, but excludes items on private prescription and all influenza items.

Taken from the Statement of Financial Entitlements, the table shows how payments are made to dispensing GP practices based on a sliding scale, the larger the number of prescription items, the lower the payment per prescription. As the payment accrues in bands, rather than a flat rate for all prescriptions submitted, it is very difficult for dispensing GP practices to predict and analyse total dispensing fee income. Full details are in Appendix 3.

Prescription Bands	Payment per Prescription from 01.04.2002 (in pence)
1-100	154.7
101-200	153.7
201-300	150.2
301-450	147.2

[36] https://www.sehd.scot.nhs.uk/publications/GMS_Statement_of_Financial_Entitlements_2020-21.pdf

Part of the way down this table, payment per prescription reduces and then increases:

Prescription Bands	Payment per Prescription from 01.04.2002 (in pence)
1351-1400	64.2
1401-1450	62.2
1451-1500	57.2
1501-1750	84.7
1751-2000	94.7
2001-2250	92.7

Set in 2002, the payment per prescription rates have not been changed.

4. Other

In addition the dispensing GP practices can receive additional discount or entitlement in the form of on cost allowance and container allowance. The nature of those discounts can be ambiguous, especially as the Statement of Financial Entitlements describes them as follows:

On cost allowance	10.5% of the basic price before deduction of any discount ("the basic price. For proprietary preparations this is the List Price as defined in the Drug Tariff. For non-proprietary items the basic price is the drug tariff price as listed in Parts 7, 7S, 7U and 9 of the drug tariff, or when not so listed, the price as determined in accordance with paragraph 13 of Part 1 of the drug tariff. The price of appliances shall be that listed in the drug tariff; less, except where the practice has been exempted under paragraph 14.7, 14.8 or 14.9 below, a discount calculated in accordance with schedule 1 to this paragraph"27)
Container allowance	3.8 pence per prescription

Recommendation 7
Current fees paid to dispensing GP practices should be reviewed

Arrangements in the rest of the UK

There are significant differences across the UK as to how dispensing GP practices who dispense medicine are remunerated and reimbursed for their services.

Within Scotland the payment mechanism for Community Pharmacies has also changed and developed over time. In 2004 the dispensing GP payment process as set out in the Statement of Financial Entitlements was very similar to that in place for Community Pharmacies. Over time, as Community Pharmacy has negotiated new arrangements, no consideration had been given to any potential unintended consequence of these changes on dispensing GP practices and the dispensing GP payment process hasn't been reviewed or uplifted.

Recommendation 8
Other payment processes in Scotland and across UK to be reviewed and report prepared to support development of a future reimbursement structure for dispensing GPs in Scotland

4. DATA

PRISMS (Prescribing Information System for Scotland[37]) provides information for all prescriptions dispensed in the community from April 2004. This is available to dispensing GP practices via a web-based application. Other prescribing activity data is available online from Public Health Scotland. Reports are updated monthly and capture each prescribing practice, prescriber type and number of items dispensed.

Practitioner Services also records prescribing, dispensing and finance data. It is possible to make formal requests for data reports to Practitioner Services based on requested parameters (provided the data is captured in the first instance) and that can be presented in a number of ways for analysis, including payments per practice monthly and annually. An example of the type of data that would be available upon request is below:

One calendar month	DP1	DP2	DP3
Gross Total	£2,807.36	£2,676.97	£559.76
Net Amount Authorised	£2,807.36	£2,676.97	£559.76
Partnership Number Items	2,940.00	347.00	134.00
Partnership Total	£13,690.18	£1,914.23	£310.25
Total Number of Items	420	347	134
Total VAT	£0.00	£0.00	£0.00
Total GIC	£1,955.74	£1,914.23	£310.25

Number of Paid Forms	565	2184	2819
Number of Paid Line Items	992	3759	5261

The Scottish Government Data and Intelligence Short Life Working Group chaired by Professor Sir Lewis Ritchie is currently exploring what data needs to be captured across general practice in Scotland and how it should be used.

Recommendation 9

Although dispensing data is available, there is a need to better understand the nature of the data that dispensing GP practices and the wider system consider to be important; for example, practice level statistics. The Data and Intelligence Short Life Working Group should be asked to consider the needs of dispensing GP practices as part of their work

5. DISPENSING SERVICE

Before a Community Pharmacy, or any other dispensary, can provide NHS dispensing services in Scotland, it must enter into a contract with a Health Board to provide a dispensing service for the NHS[38]. This contract then forms the agreement to provide a dispensing service. For 17C and 17J independent contractor dispensing GP practices this is part of their GMS contract. This doesn't apply for 2C practices that are run by their local Health Board.

According to ISD statistics, since 2014, there have been no new dispensing GP practices contracted[39].

[37] https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Prescribing-Datamarts/#prisms
[38] https://www.isdscotland.org/health-topics/prescribing-and-medicines/community-dispensing/pharmacy-services/
[39] https://dispensingdoctor.org/news/six-fewer-scottish-dispensing-practices/

The dispensary

Activities to support procurement, storage, stock management, dispensing, quality assurance and remuneration, to name but a few processes, vary from dispensary to dispensary across Scotland as there are no nationally agreed Standard Operating Procedures, guidance, processes or procedures.

For example, in 2C practices on Orkney and Shetland, additional issues are encountered where there can be delays due to the number of steps needed to provide a patient with their medication:

- The GP issues the prescription.
- It is physically taken to the pharmacy.
- The pharmacy processes the prescription, which may result in calls to and from the practice staff.
- Issuing desired medication.
- Collection by the patient / Delivery to the patient.

These can be particularly challenging if a medication change is needed or at times when the Community Pharmacy is managing a particularly high workload. The patient may not receive their medication in a timely manner and this cannot be resolved by the practice as there is limited medication available within the dispensary to remedy the situation.

The DDA, which is a UK wide membership organisation, provides useful information and support to dispensing GP practices including those in Scotland, but not every dispensing GP practice is a member of the DDA. NHS Highland produced guidance for their dispensing GP practices in North Highland in 2015, which has been tested and updated and shared with all Highland dispensing GP practices.

The Dispensing Group commissioned NHS Highland to update this guidance in 2019 with the aim to achieve endorsement as national guidance available to all dispensing GP practices. This work has not yet been progressed to allow resources to be focussed on the pandemic response. When this guidance is reviewed, the lessons of the pandemic and any implications of BREXIT will need to be considered.

The dispensing of medication to fulfil a patient's prescription is often undertaken by a dispenser, but it could also be done by the GP or a member of the dispensing GP practice staff, such as a receptionist or General Practice Nurse. There are a series of checks and quality measures in place which should be carried out before medication is dispensed to patients. For example, that the label matches the prescribed patient, the correct medicine, the quantity and dosage being prescribed as per the prescription. Such quality measures and checks are set by the dispensing GP practice to ensure compliance with legislative requirements and ensure patient safety.

Recommendation 10
NHS Highland dispensing guidance should be updated, endorsed and shared for use by all dispensing GP practices in Scotland

6. IT

In the digital world, GPs and dispensing GP practices need reliable IT to support both their general practice and their dispensary. With variation across all dispensing GP practices for both their GP IT (Vision or EMIS) and their dispensing software, there had been some concern that the new

framework[40] for the supply of GP IT systems had not taken dispensing GP practices dispensing needs into account. However, the national GP IT Reprovisioning team has advised that the existing dispensing IT being used by dispensing GP practices in Scotland has been captured and their requirements now sit as a core agenda item on their governance Board.

The national Digital Prescribing and Dispensing Pathways Programme (DPDP) is currently exploring digital options across prescribing to dispensing pathways. This work includes key themes around a digital signature and the removal of the paper prescription. Phase one of the work has been commissioned by Scottish Government to consider the digital approach from a GP to a Community Pharmacy. The next steps will consider how the identified solution may be scaled to other prescribing pathways and this will include dispensing GP practices.

Stock / Quality control

Following procurement of medication, dispensaries need to comply with storage regulations and to manage their stock flow. Many dispensing GP practices have procured stand-alone dispensing stock software such as DispenseIT to mitigate the risk of human error in that process.

Using a barcode database of medicine, the software facilitates a scanned check between the prescribed item and the bar code of the item dispensed. Where they match, a label is printed and can be attached to the dispensed item. Where they don't, staff are prompted to investigate further.

The national GP IT Framework Team had undertaken a survey to capture the GP and Dispensing software packages being used by Dispensing GP practices. In summary there are 49 practices using EMIS, and 45 using Vision 3 (produced by Cegedim) for their GP IT.

Where there is a lack of appropriate IT support, the ongoing, manual management of stock can be time consuming. Nevertheless, dispensing GP practices are proactive in their desire to ensure their processes and quality checks ensure safe dispensing for their patients.

Recommendation 11
Dispensing GP practices IT requirements for stock control, prescribing and dispensing to be reviewed and considered in line with other initiatives such as GP IT Reprovisioning, DPDP, ePrescribing and ePharmacy

Training

Within small GP practices everyone has their own role to undertake, but there can be occasions when staff undertake activities in addition to their core role to support the general practice and dispensary.

Online training is currently available for dispensing staff to access through the Buttercups distance learning modules[41]. As there are no agreed national training standards for dispensing GP practices some consider Buttercups training not suitable or appropriate for Scottish dispensing GP practices.

The NHS Highland draft Quality Standards provides guidance and best practice across several dispensing GP practice activities that reflect the British Medical Association's Dispensary Services Quality Scheme[42] (as used in NHS England) and the General Pharmaceutical Council's

[40] The new multi-supplier framework procured by NHS Scotland with EMIS, Eva and Vision, facilitates the development of a core GP IT system in line with the requirements of Scottish GPs.
[41] https://www.buttercupstraining.co.uk/course-browse/pharmacy-technicians
[42] https://www.bma.org.uk/advice-and-support/covid-19/gp-practices/covid-19-toolkit-for-gps-and-gp-practices/service-provision

professional and training standards[43] that apply to community pharmacists. They also set out the training needs of practice staff who are delivering dispensing services.

Prior to the pandemic the Remote and Rural Health Education Alliance (RRHEAL) the rural part of NHS Education for Scotland (NES) was approached by the Dispensing Short Life Working Group to consider developing a bespoke Scottish dispensing staff training programme based on the NHS Highland guidance. Unfortunately, this work had to be paused due to the pandemic but there are opportunities to begin exploring this work again.

RRHEAL also works closely with the Scottish Rural Medicine Collaborative[44] to design, deliver and advise on remote, rural and island healthcare education in Scotland. It has recently begun a consultation to provide evidence to support the development of a programme of work that would provide, affordable, standardised education and training for multidisciplinary rural clinical practitioners at advanced practice level.

Costs for training courses were historically met by the dispensing GP practice as the employer, and in addition there were concerns about releasing staff to undertake training, due to backfill issues as well as appropriate supervision. To provide support to dispensing GP practices, in 2019 the Scottish Government allocated a two-year funding stream that offered an opportunity to staff who undertake dispensing activities to apply for funding for an accredited NVQ training course (Buttercups)[45]. However, only a small number of practices applied, as it is neither a contractual nor a statutory requirement to complete the training.

The unique arrangements concerning 2C practices, where the Health Board provides staff, training, particularly for staff on some very remote islands, will need to be considered.

A digital repository or website should be developed for Scottish dispensing GP practices to allow networking, sharing of learning and good practice, training, quality standards and networking.

Recommendation 12
Review the draft Quality Standards and the training needs of dispensing staff including managers, dispensers and clinical staff and feed into the development of bespoke accredited online Scottish training courses through RRHEAL

Recommendation 13
Develop a digital repository or website for Scottish dispensing GP practices

Community Pharmacy chains and Independent Pharmacies

Over the years, Community Pharmacy chains and independent providers have recognised that there may be business opportunities in providing services to rural communities in Scotland. This is one of the reasons why the number of dispensing GP practices in Scotland has been in decline over the last decade as Community Pharmacies have opened and the dispensing GP practice has had to stop dispensing while continuing to provide GMS services. Where an income stream is potentially destabilised by a Community Pharmacy opening, this may result in disincentive to join a dispensing GP practice.

Dispensing GP practices in some areas remain concerned about the putative threat from Community Pharmacies and the potential impact on the practice funding, staff and sustainability.

[43] https://www.pharmacyregulation.org/standards
[44] https://www.srmc.scot.nhs.uk/
[45] https://www.publications.scot.nhs.uk/details.asp?PublicationID=6688

However, there are a small number of exceptional examples where the partner of a dispensing GP practice opened a Community Pharmacy and employed a pharmacist in separate premises e.g. Aultbea and Gairloch Medical Practice.

There is a complex application process in place which Community Pharmacies must follow to get approval from the health board to open a new pharmacy premises. There are opportunities for the practices and local community to be consulted and comment during this process.

Recommendation 14
Explore the development of a support package for practices that are ceasing to dispense following the opening of a Community Pharmacy, to ensure their sustainability in the future

RECOMMENDATIONS AND NEXT STEPS

The following recommendations are submitted to the Dispensing Short Life Working Group for consideration and agreement. It is also recommended that there is collaboration with members of this group to form plans and activities that capture suggestions on how each of the recommendations should be approached and applied in practice.

Recommendation 1
A business continuity toolkit and related resources, specifically aimed at supporting dispensing GP practices, should be developed.

Recommendation 2
As set out in the Memorandum of Understanding Two, Scottish Government, HSCPs and Health Boards continue to implement the roll out of Pharmacotherapy services to all GP practices, including dispensing GP practices.

Recommendation 3
To help to inform negotiations around Phase 2 analysis of dispensing GP practice Income and Expenditure should be progressed to understand the financial implications of dispensing.

Recommendation 4
Further investigate the impact of differences in SFE and HMRC regulations on Dispensing GP practices. Additional support and training to GPs and Practice Managers on how to manage financial processes including VAT should be considered.

Recommendation 5
The impact of changes to drug tariff on dispensing GP practices needs to be better understood and communicated to dispensing GP practices and how dispensing GP practices can be better involved in the drug tariff process should also be considered.

Recommendation 6
An electronic process for dispensing GP practices, facilitating clear payment details, similar to that in place for Community Pharmacies, should be developed and implemented as a priority.

Recommendation 7
Current fees paid to dispensing GP practices should be reviewed.

Recommendation 8
Other payment processes in Scotland and across UK to be reviewed and report prepared to support development of a future reimbursement structure for dispensing GPs in Scotland.

Recommendation 9
Although dispensing data is available, there is a need to better understand the nature of the data that dispensing GP practices and the wider system consider to be important; for example, practice level statistics. The Data and Intelligence Short Life Working Group should be asked to consider the needs of dispensing GP practices as part of their work.

Recommendation 10
NHS Highland dispensing guidance should be updated, endorsed and shared for use by all dispensing GP practices in Scotland.

Recommendation 11
Dispensing GP practices IT requirements for stock control, prescribing and dispensing to be reviewed and considered in line with other initiatives such as GP IT Reprovisioning, DPDP, ePrescribing and ePharmacy.

Recommendation 12
Review the draft Quality Standards and the training needs of Dispensing staff including managers, dispensers and clinical staff and feed into the development of bespoke accredited online Scottish training courses through RRHEAL.

Recommendation 13
Develop a digital repository or website for Scottish dispensing GP practices.

Recommendation 14
Explore the development of a support package for practices that are ceasing to dispense following the opening of a Community Pharmacy, to ensure their sustainability in the future.

IN CONCLUSION

Having undertaken a deep dive into dispensing GP practices in Scotland, it is clear they provide an essential role within remote, rural and very remote rural communities across Scotland. In addition to the GP services offered, should there be no access to a Community Pharmacy, dispensing GP practices also ensure their patients have access to prescribed medication.

These practices are resilient in their need to adjust and adapt to changing policy, IT and practice. Their remoteness and, generally, small staffing complement, for example, did not impede their speedy responses to Public Health and Scottish Government pandemic guidance. By implementing infection control changes to their procurement activities and how they dispensed medication, they ensured continuance of their high quality, safe service to their patients during very challenging times.

Nevertheless, from the outset of discussions, it was clear that there are a range of opportunities and challenges facing Dispensing GP practices. To address these, the recommendations set out in this paper aim to meet the needs of dispensing GP practices in Scotland and ensure their sustainability for many years to come.

This report is being submitted to the members of the Scottish Government Dispensing Short Life Working Group for discussion and consideration of the recommendations detailed herein.

Approval to progress with the establishment of a formal programme of work will be sought thereafter from the Remote and Rural Working Group.

Linda Kerr

CONTRIBUTORS

As with every area of our life, the global pandemic has resulted in challenges around our approach to 'normal' activities, impacting on time and availability to undertake our respective roles. I wish to take a moment to acknowledge the efforts made by everyone who contributed to this document, for sharing their amazing depth of knowledge, their views, advice, supporting papers and (couldn't have done it without) humour! Thank you.

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APPENDIX 1: DISPENSING GP PRACTICES SHORT LIFE WORKING GROUP - MEMBERSHIP (2019)

NAME	DESIGNATION	ORGANISATION
Fiona Duff	Chair	Primary Care Division, Scottish Government
Alison Strath	Principal Pharmaceutical Office, Pharmacy Division	Scottish Government
Andrew Buist	General Practitioner and Chair of SGPC	SGPC
Andy Vickerstaff	Dispensing Practice Manager	NHS Highland
Chris Nicholson	Director of Pharmacy	NHS Shetland
Clare Morrison	Quality Improvement Advisor	NHS Highland
David Prince	Head of Primary Care	SGPC
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Hal Maxwell	General Practitioner	Dispensing Doctors Association
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Jurgen Tittmar	General Practitioner	Rural GP Association (RGPAS)
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Maureen Firth	Primary Care Manager	NHS Orkney
Ross Grant	Secretariat	Scottish Government

APPENDIX 2: DISPENSING GP PRACTICES IN SCOTLAND

There are three different types of dispensing GP practices in Scotland:

- A **section 17C** practice is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances.
- A **section 17J** or General Medical Services practice is one that has a standard, nationally negotiated contract.
- In general terms, a **2C practice** is most likely to mean that the practice is run by the NHS Board, as opposed to being run by GPs and/or other partners, as is the case for practices with 17C or 17J contract types)

The following is an alphabetical list of dispensing GP practices in Scotland as of 1 October 2020[46]. The practice list size depicts the total list. It should be noted that larger practices may not be permitted to dispense to all of their patients on the list.

Practice Name	Contractual status	Practice list size
Aberfeldy And Kinloch Rannoch Medical Practice	17J	4,655
Aberfoyle & Buchlyvie Medical Centres	17J	2,349
Acharacle Medical Practice	2C	1,341
Applecross	2C	231
Armadale Medical Practice	17J	883
Arran Medical Group	17C	4,976
Assynt Medical Practice	17J	904
Auchenblae Medical Centre	17J	2,021
Auchtermuchty Practice	17J	5,664
Ballachulish Medical Practice	2C	1,570
Ballantrae Medical Practice	17C	1,522
Barra Medical Practice	17J	1,246
Benbecula Medical Practice	17J	2,303
Bixter Health Centre	2C	1,203
Blackwood Medical Practice	17J	3,765
Cairn Valley Medical Practice	17J	3,927
Cairnsmore Medical Practice	17J	3,827
Canisbay & Castletown Joint Medical Practice	17J	2,866
Canonbie Surgery	17J	2,183
Carbost Medical Practice	2C	651
Crimond Medical Centre	17J	3,427
Dailly Medical Practice	17J	1,352
Daisy Villa	17J	1,526
Douglasdale Medical Practice	17J	5,374
Dr A MacGregor & Dr N Hallum	17J	1,086
Dr C O'Neill	17J	178
Dr David F Troup & Partner	17J	1,095
Dr Lorna M Macgregor & Partner	17J	798
Dr Malcolm R Elder	17J	582
Dr P M R Von Kaehne	17J	480
Dr Robert S B Coull	17J	902
Dr Tittmar and Partner	17J	1,558
Drs E Manasses & Partners	17J	3,400
Dunbeath Surgery	17J	626
Dunvegan Medical Practice	17J	1,772

[46] https://www.isdscotland.org/Health-Topics/General-Practice/GPs-and-Other-Practice-Workforce/Glossary.asp#:~:text=2C%20practice%3A%20In%20general%20terms,17C%20or%2017J%20contract%20types).

Practice Name	Contractual status	Practice list size
Easdale Medical Practice	17J	1,056
Ecclefechan Surgery	17J	2,792
Eyemouth Medical Practice	17J	6,449
Galloway Hills Medical Practice	17J	4,548
Glenelg Health Centre	2C	250
Glenkens Medical Practice	17J	1,792
Glenlivet Medical Practice	17J	587
Glenluce Surgery	17J	1,871
Haddo Medical Group	17J	5,445
Hillswick Health Centre	17C	808
Inverurie Medical Group	17C	24,613
Islands View Surgery	2C	249
Jura Medical Practice	17J	235
Kinlochleven Medical Practice	17C	885
Kintyre Medical Group	2C	1,130
Kippen Surgery	17J	2,163
Langabhat Medical Practice	17J	5,189
Levenwick Medical Practice	17C	2,738
Linkwood Medical	17J	11,693
Loch Ness East And Strathnairn - Foyers	17J	1,006
Lochaline Medical Practice	17J	329
Lochcarron Medical Partnership	17J	926
Lybster Medical Centre	2C	1,141
Macduff Medical Practice	17J	12,225
Mull & Iona Medical Group	17J	3,352
Mull of Galloway Practice	17J	718
Munlochy Medical Practice	17J	3,362
Newcastleton Medical Practice	17J	1,541
North Harris Medical Practice	17C	1,250
North Uist Medical Practice	17C	1,387
Orcades Practice	2C	1,929
Port Ellen Surgery	17J	1,277
Portlethen Medical Centre	17C	15,183
Rinnes Medical Group	17J	2,880
Sandhead Surgery	17J	2,412
Scalasaig Medical Practice	17J	138
Scotstown Medical Group	17C	12,141
Scourie, Kinlochbervie and Durness Medical Practice	2C	886
Shebburn Medical Practice	17J	2,751
Skene Medical Group	17C	15,154
Small Isles Medical Practice - Isle of Eigg	2C	198
South Harris Medical Practice	17J	560
South Skye Medical Practice	2C	2,838
South Uist Medical Practice	17J	1,007
Southern Machars Practice	17J	3,099
Stow & Lauder Health	17J	4,605
Strathdon Medical Centre	17J	791
Taynuilt Medical Practice	17J	5,142
The Group Practice	17C	7,890
The Moffat Surgery	2C	5,264
The Rhinns Medical Centre	17J	784
Thurso & Halkirk Medical Practice	17J	6,057
Tiree Medical Practice	17J	697
Tongue Medical Practice	17J	488
Torridon Medical Practice	2C	432
Unst Health Centre	2C	597
Walls Health Centre	2C	705
Whalsay Health Centre	2C	1,083
Yell Health Centre	2C	977

14. Dispensing

14.1. Payment is made for the supply of drugs and appliances only where they have been supplied by a dispensing practice in accordance with arrangements made under Schedule 6, Part 3 of the 2018 Regulations. In this and the following paragraphs, "appliances" means appliances listed in the Drug Tariff (i.e. the Statement prepared by Scottish Ministers under regulation 9 of the National Health Service (Pharmaceutical Services)(Scotland) Regulations 2009, as amended).

14.2. Some practices are prescribing practices as well as dispensing practices, i.e. their lists include some patients who can conveniently obtain their medicines etc. from chemists, and for whom, accordingly, the practice is not required to dispense medicines but to write prescriptions and hand them to the patient in the ordinary way. This section does not apply to the supply of drugs and appliances to these 'prescribing patients' but only to those 'dispensing patients' for whom the practice has been required by the Health Board to dispense.

14.3. Payments to dispensing practices for drugs, appliances, etc. supplied to patients on the practice dispensing list, temporary residents and patients who are receiving maternity medical services or contraceptive services from the practice (and in respect of whom the Health Board have required the practice to dispense) shall be as follows:

a) the basic price. For proprietary preparations this is the List Price as defined in the Drug Tariff. For non-proprietary items the basic price is the Tariff price as listed in Parts 7, 7S, 7U and 9 of the Drug Tariff, or when not so listed, the price as determined in accordance with paragraph 13 of Part 1 of the Drug Tariff. The price of appliances shall be that listed in the Drug Tariff;

   less, except where the practice has been exempted under paragraph 14.7, 14.8 or 14.9 below, a discount calculated in accordance with schedule 1 to this paragraph;

b) an on-cost allowance of 10.5% of the basic price before deduction of any discount under schedule 1;

c) a container allowance of 3.8 pence per prescription;

d) a dispensing fee as shown in schedule 2 to this paragraph, other than in relation to appliances and oxygen therapy equipment;

e) an allowance in respect of VAT in accordance with paragraph 14.5 ; and

f) if appropriate, exceptional expenses in accordance with paragraph 14.6.

A practice may not claim payment under this paragraph for a vaccine specified in Schedule 4 (a) .

14.4. Payments in respect of the supply of oxygen therapy equipment shall be made in accordance with the provisions of part 10, paragraph 6 of the Drug Tariff and shall not be subject to these discount arrangements.

14.5. **For the dispensing period 1 July 2011 onwards** A VAT allowance shall be paid to cover any VAT payable on the purchase of any products listed below for personal administration under a GMS contract:

a) vaccines, anaesthetics and injections;

b) the following diagnostic reagents: Dick Test; Schick test; Protein Sensitisation Test Solutions; and Tuberculin Tests (i.e. Koch Test, Mantoux Test, Patch Test and Diagnostic Jelly);

c) intrauterine contraceptive devices (including drug- releasing IUCDs, contraceptive caps and diaphragms);

d) pessaries which are appliances; and

e) sutures (including skin closure strips).

No allowance will however be paid for any item which is centrally supplied as part of a programme such as the Childhood Immunisation Programme or any programme against a Pandemic Influenza Virus.

14.6. Where additional expenses have been incurred in obtaining from a manufacturer or wholesaler supplies of a drug or appliance (other than those items for which prices are given in Parts 2-5, 7, 7S and 9 of the Tariff), which a practice does not frequently require to provide, payment of the amount incurred will be authorised if the practice submits a claim giving full details to the Health Board with the appropriate prescription form and if, in any doubtful cases, the Health Board, after consultation with the GP Subcommittee of the Area Medical Committee, is satisfied that the additional expenses were necessarily incurred and were reasonable.

14.7. Where a practice is able to provide evidence and the Health Board, after making such enquiries as it deems necessary and after consulting the GP Subcommittee of the Area Medical Committee, is satisfied that by reason of the remoteness of the practice the practice is unable to obtain any discount on the basic price (see paragraph 14.3) for the purchase of drugs and appliances the Health Board shall approve the exemption of the practice from the application of the discount scale. In such cases the Health Board shall inform Practitioner Services Division of the period during which the exemption should be applied. Payments will then be calculated on the full, and not the discounted, basic price. Such an exemption may be granted for a period of up to one year and may be renewed for further such periods

if the practice is able to satisfy the Health Board that the practice continues to be unable to obtain any discount.

14.8. Where:

a) a practice is able to provide evidence; and

b) the Health Board after making such enquiries as it deems necessary and after consulting the GP Subcommittee of the Area Medical Committee is satisfied;

c) that by reason of :

i. the remoteness of the practice; or

ii. the small quantities of drugs and appliances the practice needs to buy (normally where the total monthly basic price to be reimbursed is below that which would attract an adjustment for discount);

the practice is only able to obtain drugs and appliances at a price in excess of the basic price (see paragraph 14.3) and on average more than 5% above the basic price then Practitioner Services Division shall approve a special payment. Practitioner Services Division shall determine the appropriate level of the special payment from the scale below:

Table 7 - Appropriate Level of Special Payment

Where on average the price paid (excluding VAT) is:	Special Payment:
in excess of 5% and up to 10% over basic price	5% over basic price
in excess of 10% and up to 15% over basic price	10% over basic price
in excess of 15% and up to 20% over basic price	15% over basic price
in excess of 20% over basic price	20% over basic price

Practitioner Services Division shall apply the rate for the special payment and the period during which it should be applied to the basic price payable. The VAT allowance (see paragraph 14.5) shall be calculated on the basic price plus the special payment. The on cost allowance shall be calculated on the basic price. No discount shall be applied. Such payments may be

granted for a period of up to one year and may be renewed for further such periods at the same or a different rate if the practice is able to satisfy the Health Board that it continues to meet the above conditions.

Transitional Arrangements.

14.9. Where a practitioner succeeds to the practice of a dispensing practitioner who at the time of their withdrawal from the performer list or medical list was:

a) exempted from application of the discount scale under paragraph 14.7 or;

b) was in receipt of the special payment provided under paragraph 14.8;

and the successor has made application to Practitioner Services Division for such exemption or special payment, Practitioner Services Division shall treat the practitioner as qualifying for the exemption or special payment as appropriate for a period of 3 months from the date of their admission to the performers list or until their application is determined, whichever is the earlier.

Claims.

14.10. Payments are based on the monthly surrender and pricing of the prescriptions issued. Prescriptions for proprietary preparations (including prescriptions for non-proprietary preparations available only in proprietary form) should be endorsed with the size of the pack used in dispensing. All the prescriptions should then be noted, counted and sent under cover of Form GP34A to the appropriate Prescription Pricing Bureau (see schedule 3) within the first week of the month following that in which the prescriptions were dispensed.

14.11. Dispensing practices must submit all prescriptions for pricing in one batch under cover of one claim form relating to the practice in order that the appropriate rate of discount under schedule 1 may be applied. Practices may if they wish sub-divide the partnership batch into bundles relating to the individual practitioners and attach separate claims to each for the purpose of calculating the dispensing fees provided that all such bundles are sent to Practitioner Services Division together in one batch for the partnership.

Payments On Account.

14.12. Monthly payments on account will be made by Practitioner Services Division based on 100% of the sum due. The estimated sum due in April (February dispensing) will be based on three times the number of prescriptions submitted for pricing and the average payments per prescription for December. Thereafter estimates will be based on 100% of December or January payments.

14.13. For prescriptions dispensed in February and submitted in March the practice should receive at the end of March 80% of the estimated sum due for February plus the balance of the sum due for prescriptions dispensed in January. Where, because the average cost of prescriptions varies significantly from month to month, it appears to Practitioner Services Division that payment of the amount notified would be likely to result in an overpayment, Practitioner Services Division will pay a lesser amount on account.

14.14. In the case of a practice who has not previously dispensed in a practice and for whom no such authorisation is available, the estimated sum due will normally be based on the last authorisation for the practice, as appropriate.

Examination Of Prescription Forms.

14.15. Priced prescription forms will not normally be returned to a practice. However any practice which has supplied drugs and appliances and which wishes to examine their prescription forms after they have been priced should inform Practitioner Services Division so that they may make the necessary arrangements. It would normally be from 2 to 6 months after pricing before the forms are available for inspection at Practitioner Services Division premises.

Accounting.

14.16. In order to ensure that the annual surveys of practitioners' practice expenses carried out by HM Revenue and Customs are as accurate as possible, practitioners should ensure that their actual expenditure on drugs and appliances are shown 'gross' in their accounts. Payments under this paragraph should be brought to account 'gross' as 'income'.

Paragraph 15/Schedule 1: Discount Scale

Table 8 - Discount Scale

Total Basic Price of all Prescriptions submitted for Pricing by Practitioner/ Practice in Month	Rate of Discount to be applied to Basic Practice %
1 – 1000	0.00
1001 – 1125	0.08
1126 – 1250	0.15
1251 – 1375	0.21
1376 – 1500	0.26
1501 – 1625	0.32
1626 – 1750	0.37
1751 – 1875	0.42
1876 – 2000	0.48
2001 – 2125	0.54
2126 – 2250	0.61
2251 – 2375	0.68
2376 – 2500	0.77
2501 – 2625	0.88
2626 – 2750	0.99
2751 – 2875	1.12
2876 – 3000	1.25
3001 – 3125	1.42
3126 – 3250	1.59
3251 - 3375	1.76
3376 - 3500	1.93
3501 - 3625	2.09
3626 – 3750	2.24
3751 - 3875	2.38

3876 - 4000	2.53
4001 - 4125	2.69
4126 - 4250	2.85
4251 - 4375	3.01
4376 - 4500	3.15
4501 - 4625	3.29
4626 - 4750	3.42
4751 - 4875	3.54
4876 - 5000	3.68
5001 - 5125	3.81
5126 - 5250	3.86
5251 - 5375	4.09
5376 - 5500	4.23
5501 – 5625	4.35
5626 - 5750	4.47
5751 - 5875	4.59
5876 - 6000	4.70
6001 - 6125	4.81
6126 - 6250	4.91
6251 - 6375	5.01
6376 - 6500	5.11
6501-6625	5.20
6626 – 6750	5.29
6751 – 6875	5.37
6876 – 7000	5.45
7001 – 7125	5.54
7126 – 7250	5.61
7251 – 7375	5.69

7376 – 7500	5.76
7501 – 7625	5.83
7626 – 7750	5.90
7751 – 7875	5.96
7876 – 8000	6.03
8001 – 8125	6.09
8126 – 8250	6.15
8251 – 8375	6.21
8376 – 8500	6.27
8501 – 8625	6.32
8626 – 8750	6.38
8751 – 8875	6.43
8876 – 9000	6.48
9001 – 9125	6.53
9126 - 9250	6.58
9251 - 9375	6.62
9376 - 9500	6.67
9501 - 9625	6.72
9626 - 9750	6.76
9751 - 9875	6.80
9876 - 10000	6.84
10001 - 10125	6.88
10126 - 10250	6.92
10251 - 10375	6.96

10376 - 10500	7.00
10501 - 10625	7.04
10626 - 10750	7.07
10751 - 10875	7.11
10876 - 11000	7.14
11001 - 11125	7.18
11126 - 11250	7.21
11251 - 11375	7.24
11376 - 11500	7.27
11501 - 11625	7.31
11626 - 11750	7.34
11751 - 11875	7.37
11876 - 12000	7.39
12000+ -	7.42

NB: Where a practitioner is in partnership the rate of discount to be applied is that which relates to the total Basic Price of all prescriptions submitted for pricing by all the partners.

Paragraph 15/Schedule 2: Fee Scale

Dispensing Fees (see paragraph 14.3) - marginal fee scale for application to prescriptions submitted for pricing by practitioner/practice per month.

Table 9 - Dispensing Fees

Prescriptions in Bands	Payment per * Prescription from 01.04.2002
1-100	154.7
101-200	153.7
201-300	150.2
301-450	147.2
451-600	142.7
601-650	122.2
651-700	119.2
701-750	115.2

751-800	113.7
801-850	108.2
851-900	103.2
901-950	100.2
951-1000	94.7
1001-1050	92.7
1051-1100	88.2
1101-1150	83.7
1151-1200	81.7
1201-1250	76.7
1251-1300	74.7
1301-1350	70.2
1351-1400	64.2
1401-1450	62.2
1451-1500	57.2
1501-1750	84.7
1751-2000	94.7
2001-2250	92.7
2251-2500	90.2
2501-2750	88.7
2751-3000	86.2
3001-3250	85.7
3251-3500	84.7
3501-3750	83.2
3751-4000	82.7
4001-4250	81.7
4251-4500	79.7
4501-4750	78.7
4751-5000	77.7
5001-5250	77.2
5251-5500	75.7
5501-5750	74.7
5751-6000	73.7
6001-6250	72.7
6251-6500	71.7
6501-6750	70.7

* Payment will be reduced by 1p per prescription for each additional 250 prescriptions per month in excess of 6,750.

Paragraph 15/Schedule 3: Address for Claims

ADDRESSES TO WHICH DISPENSING PRACTICES SHOULD SUBMIT THEIR CLAIMS
Practitioner Services Division (Pharmacy)
3 Bain Square
Livingston
EH54 7DQ

Paragraph 15/ Schedule 4: List of Vaccines

Subject to the provisions of b) below, no payments are payable under paragraph 14 in respect of the products listed in paragraph a) below, which are centrally supplied as part of the Childhood Immunisation Programme-

a) MMR (Measles, Mumps and Rubella); BCG (Bacillus Calmette-Guerin); Tuberculin Purified Protein Derivative; Meningococcal C conjugate vaccine and Rotavirus (for children under 5 and persons entering the first year of higher education);

   DTaP/IPV/HiB (Diphtheria/Tetanus/Pertussis/Inactivated Polio/Haemophilus influenzae type B); dTaP/IPV (low doDiphtheria/Tetanus/Pertussis/Inactivated Polio); DTaP/IPV (Diphtheria/Tetanus/Pertussis/Inactivated Polio); and Td/IPV (Diphtheria/Tetanus/ Inactivated Polio); HiB/MenC (Haemophilus influenzae type B/meningitis C) and PCV/PPV (pneumococcal);

b) payments are payable under this Section in respect of Td/IPV (Diphtheria/Tetanus/ Inactivated Polio) where that product is used for the treatment of adults or supplied to patients who require such products prior to travelling outside the United Kingdom and in either case where the Td/IPV product has been purchased by the contractor directly from the manufacturer.