The Future For Dispensing Doctors In The NHS Ten Year Plan

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Context

- Published June 2025
- Designed to respond to Lord Darzi’s review of NHS commissioned July 2024 on Labour coming to power
- Sets a vision for the NHS
- Published by a government expecting a ten year term in office
- Follows a consultation with stakeholders
- Refers to England only but likely to have consequences for devolved nations

Darzi Report Key Headlines

“The NHS is in Serious Trouble” (No Mention Dispensing)

The first step to rebuilding public trust and confidence in the NHS is to be completely honest about where it stands

The state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance

This report sets out where the NHS stands now, how we arrived at this point, and some of the key remedies

How long people wait, and the quality of treatment, are at the heart of the social contract between the NHS and the people. The NHS has not been able to meet the most important promises made to the people since 2015

Darzi Report Key Headlines

People are struggling to see their GP

Waiting lists for community services and mental health have surged

A&E is in an awful state

Waiting times for hospital procedures have ballooned

Cancer care still lags behind other countries

Care for cardiovascular conditions is going in the wrong direction

The picture on quality of care is mixed

Darzi Report on GPs

The NHS budget is not being spent where it should be - too great a share is being spent in hospitals, too little in the community, and productivity is too low

The NHS is not contributing to national prosperity as it could

GPs are seeing more patients than ever before, but with the number of fully qualified GPs relative to the population falling, waiting times are rising and patient satisfaction is at its lowest ever level. There are huge and unwarranted variations in the number of patients per GP, and shortages are particularly acute in deprived communities.

We have almost 16% fewer fully qualified GPs than other high income countries (OECD 19) relative to our population.

Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community. In practice, the reverse has happened.

The result is that NHS has implemented the inverse of its stated strategy, with the system producing precisely the result that its current design drives.

Darzi on G.Ps

3**3. As independent businesses, General Practices have the best financial discipline in the health service family** as they cannot run up large deficits in the belief that they will be bailed out. Despite rising productivity, an expanding role, and evident capacity constraints, the relative share of NHS expenditure towards primary care fell by a quarter in just over a decade, from 24 per cent in 2009 to just 18 per cent by 2021, continuing a downward trajectory from their peak in 2004268

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34. With primary care doing more work for a lesser share of the NHS budget, we heard significant irritation felt by GPs who perceive that more and more tasks are being shifted from secondary care back to primary care, with a never-ending flow of letters demanding follow-ups and further investigations. This frustration is understandable when the hospital workforce appears to have expanded to the amongst the highest levels in the world.

Darzi Proposed Solutions

‘**Lock in the shift of care closer to home by hardwiring financial flows.** General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population ages.
Financial flows must lock-in this change irreversibly or it will not happen.”

“Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: **we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.”**

Immediate Reflections

- NHS Ten Year Plan is not a plan but an aspirational vision
- We know it had several iterations and authors
- **Expected chapter on funding and implementation absent !**
- It’s long ! 166 pages and urban centric
- It hardly mentions GPs
- It does not mention Dispensing Doctors
- It mentions “dispensing” four times
- Nothing on social care reform - Casey review due to report sometime in 2026

Dispensing Quotes (page 37)

- “Over the next five years we will transition community pharmacy from being focussed largely on **dispensing** medicines to becoming integral to the neighbourhood health service, offering more clinical services”
- “We now get many of life’s essentials delivered straight to our home. Medicines should not be an exception. Over the first half of this plan we will modernise our approach to the **dispensing** of medicines and make better use of the technology available, including **dispensing** robots and hub and spoke models. We will engage with the sector and public on proposals for modernising medicine **dispensing** so that it is fit for the 21st century”

My Interpretation Of That

- Free up community pharmacist time so they can deliver more clinical services
- Support remote dispensing models and internet pharmacy
- Author probably does not know dispensing doctors exist!
- Assumes most community pharmacists are competent in delivering clinical services and have premises designed for delivering them
- Focus on funding for clinical services not dispensing fees
- Neighbourhood contracts (more later) will contract with or include community pharmacy
- Nothing here to make us feel a future for dispensing doctors has been considered

Ten Year Term?

- Hmmm!
- And will Wes Streeting be
- Prime Minister
- Before next election?

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General Election Prediction

Updated 23 August 2025

Current Prediction: Reform majority 86

Party	2024 Votes	2024 Seats	Pred Vot
CON	24.4%	121	17.9%
LAB	34.7%	412	21.2%
LIB	12.6%	72	13.6%
Reform	14.7%	5	30.3%
Green	6.9%	4	8.8%
SNP	2.6%	9	2.6%
PlaidC	0.7%	4	0.8%
Other	3.5%	5	4.7%

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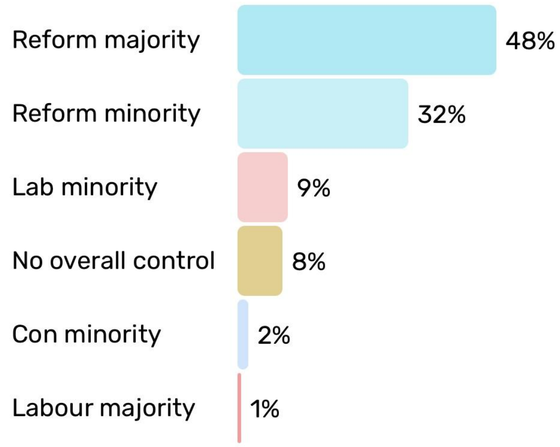
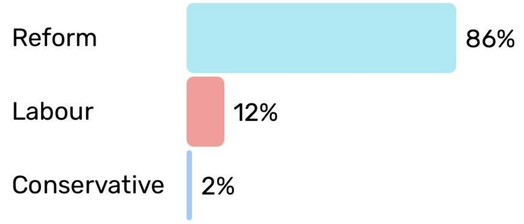
Probability of possible outcomes



Probability of being the largest party



The future is never certain. But using our advanced modelling techniques, we can estimate the probability of the various possible outcomes at the next general election. Minority government probabilities assume possible alliances between the Conservative and Reform parties, and

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Back To The Plan -It’s Three Main Thrusts

- From Hospital to Community
- From Analogue to Digital
- From Sickness to Prevention

Neighbourhood Contracts

- 1) **Single Neighbourhood Providers**
- Designed around population of c.50,000 population ,building from PCNs
- **2) Multi-neighbourhood providers of c.250,000 population (function?)**
- Plan does recognise services will look different in rural areas
- No mention how these interact and inter-relate to GPs
- GMS/PMS/APMS contracts not mentioned in document
- Funded by “increased share of NHS budget” **NOT BIGGER BUDGET NOTE!**

‘As we do more in the community - funded by a reduction in hospitals’ share of total NHS expenditure - we will reduce demand on hospitals.” Page 28.

Multi Neighbourhood Providers

“Multi-neighbourhood providers will also be responsible for unlocking the advantages and efficiencies possible from greater scale, working across all GP practices and smaller neighbourhood providers in their footprint.
They will support sustainability and professional autonomy by delivering a shared back-office function, overseeing digital transformation and estate strategy, and by providing data analytics and a quality improvement function.
They will be large enough to create new commercial partnerships, including clinical trials, so that the Neighbourhood Health Service becomes a hotbed for innovation. And they will actively
support and coach individual practices who struggle with either performance or finances - including by stepping in and ***taking over when needed”***

Neighbourhood Contract Questions?

- Will they replace GMS/PMS?
- Document does say
- “Where the traditional model is working well it should continue but we will create an alternative for GPs”
- “We will encourage GPs to work over larger geographies by leading neighbourhood providers”
- What implications are there for controlled localities and rights to dispense?
- How will Pharmaceutical Needs Assessments recognise “neighbourhoods”?
- Wes Streeting has re-committed to a new GMS contract in this parliament

Neighbourhood Contracts

- Will they hold some or all GMS/PMS contracts?
- Will they commission primary care?
- What will their budget be? And what will it cover?
- Will they employ community staff or just manage them?
- How do they relate to community pharmacy? And Dispensing Doctors?
- If their budget gets tight, will they cost shift and work dump onto GMS/PMS
- Who employs the GPs on boards ,who indemnifies them?

National Neighbourhood Health Implementation Program

- This is meant to scope some of the issues , £10 million allocated
- Lots of practices and PCNs have applied and pilots announced
- Encouraged by BMA so to do
- It’s led by Sir John Oldham , who was a GP and is passionate advocate for GPs
- He states trusts should not run neighbourhood contracts
- But that is what has happened in London already!
- Probably low risk to apply , but beware of being cast as the “future”

The Biggest Risk That I See Hidden in the Plan

- Page 13
- “Reinvent the NHS foundation trust model for modern age. By 2035 our ambition is that every NHS provider should be an FT with freedoms including the ability to retain surpluses and reinvest them and borrowing for capital investment. FTs will use these freedoms to improve population health not just increase activity.
- Create a new opportunity for the very best **FTs to hold a budget for a defined population** as an Integrated Health Organisation (IHO). Our intention is to designate a small number of these IHOs in 2026 with view to them becoming operational in 2027. **Over time they will become the norm.”**

IHOs

- Be afraid ,be very afraid if this happens!
- Last time FTs stripped all the money away from Mental Health,Community and General Practice through “payment by Results (ACTIVITY!)
- Does all NHS Providers means trusts or GPs, pharmacy, neighbourhoods?
- Does this not go against purchaser/provider split?
- Built on year of care budgets also trailed in the plan to include primary care
- So IHO has budget for population but also provides care?
- Back to the future of District health Authorities!

Year of Care Budgets (YCBs) (page135)

“These allocate a capitated budget for a patient’s care over a year, instead of paying a fee for a service”

“This new payment mechanism will be calculated according to the health needs of the population being served and will allow providers to invest in high-quality, proactive and planned care for patients. ***The YCP could include all primary care, community health services, mental health, specialist outpatient care, emergency department attendances and admissions. These will be consolidated into a single payment.***

The YCB will provide a sharp incentive to keep patients healthy and out of hospital because local NHS organisations will benefit from reducing emergency visits and reinvesting in community services.”

Year of Care Budgets page 135

“These YCPs will be an important feature of our new payment system, and of the neighbourhood provider contracts described in chapter 2, for specified populations or services. Operating at a larger scale, Integrated Health Organisations, described in chapter 5, will take on budgets for the entire population being served.”

Will this include dispensing fees ?

Will this replace cost envelope?

How will this cover drug costs ?

Year of Care Budgets. (Page135)

‘From financial year 2026 to 2027, we will begin intensive work with a small number of ‘pioneer’ systems who are already further advanced in designing their new care model to implement notional YCPs. The development of both YCP and tariffs for community and mental health services will be dependent on the availability of good quality cost and activity data. To support this change, a suite of community and mental health service currency models have been developed and included in the 2025 to 2026 NHS Payment Scheme.”

Funding Formula Review (page137)

“We expect the ACRA review to report in time to inform allocation of resources to and by ICBs in 2027 to 2028 and, in the meantime, we will target extra funding to areas with disproportionate economic and health challenges. We will also review how health need is reflected in nationally determined contracts, such the Carr-Hill formula for General Practice. “

IHOs and YCBs

- At least we are reassured page 81
- “They will always and only ever be NHS organisations”
- But how do they interact with GPs and neighbourhoods?
- Do they contract with them? And commission them?
- Do they replace them and provide all neighbourhood services?
- **I think this clause reveals the covert end game!**

Implications

- Note revision of Carr Hill promised (again) for primary care
- Will the review reflect rurality and increased costs of provision in these areas?
- Will undoubtedly direct more resource to deprived communities in cities where health outcomes worst
- However , biggest weighting of health care spend is age and those in more affluent communities live longer!
- And most importantly is this slicing the cake differently or increasing the size of the cake!
- Could mean winners and losers and will rural areas be the losers?

The Cost of Change

- Moving services to community requires a period of investment not just cost shifting and “double running”
- Promoting choice means providing an excess of capacity
- Capital costs for new neighbourhood health centres (?PFI)
- Capital for equipment
- Increased funding for longer opening hours (12 hours six days)
- Where is this funding?

NHS APP

- Likely to increase competition to dispensing services
- Need to ensure dispensary is an option for patents to choose
- Likely to increase competition for vaccines delivery
- Will it become the front door of the NHS?
- Will the “doctor in the pocket” AI advice, reduce or increase demand ?
- Will it allow patients to directly book consultations with us or other providers?
- Seen as integral for reducing the 8am scramble for appointments and promises same day appts for those who need them!

The Road to the End Game , (My View)

- Size up GPs into bite sized chunks -started with PCNs, now neighbourhoods ,then multi neighbourhood providers, then IHOs
- Offer bribes (sorry incentives) to neighbourhoods and let GMS and dispensing wither on the vine but keep new contracts “voluntary” (think PCN DES)
- Becomes non viable to remain GMS/PMS as LESs and DESs go to neighbourhoods (as with PCNs)
- Allocate fixed budgets to neighbourhood contracts built from year of care budgets
- Move primary care commissioning locally to IHOs
- End national negotiation of GMS/PMS
- GPs become part of neighbourhood contract and then IHO and salaried

Latest (Informally) From NHSE

- Draft neighbourhood contracts to be shared and consulted on “after the summer”
- They will be voluntary
- This will be an overlay to GMS/PMS/APMS and not require forfeiture of these core contracts
- PCN DES will also remain
- New neighbourhood contract to be less bureaucratic than GMS or PCN DES
- Will allow more flexibility staffing and resourcing than GMS
- Likely to appeal most to single practice PCNs or enthusiastic collaborative PCNs

What can we do now?

- We need BMA/GPC to stand up to this (they are on the case)
- We need a new GMS/PMS contract that builds investment into practice not just PCNs and neighbourhoods
- WE need BMA to actually recognise, understand and properly represent Dispensing Doctors in any negotiations
- LMC conference Agenda committee rejected a motion to this end last year!
- Propose motions to your LMC for LMC conference next year
- Examine any detail as it emerges

Don’t Give Up

- NHS 10 year Plan visionary but lacks any funding or implementation details
- Over 50% managers in NHSE and ICBs being made redundant
- That’s a big redundancy bill , where does money come from?
- So who is going to do all this work?
- Government face huge challenges with economy and immigration
- They are also very short of cash and deeply unpopular
- **My opinion is in 2035 most of this won’t have happened as written!**

DD Issues submitted to GPC

- Zero clawback for Discount non deducted drugs (now allowed for inclisiran) -not available to us but is to pharmacy
- Dispensing fee envelope needs review and reform
- Funding for IT for dispensing
- EPS -note new contractual clause saying you must dispense a token presented to you!
- Differential impact of GMS uplifts for Staff costs as Dispensing Doctors employ more
- Representation in negotiations

Challenges to BMA

- Appoint a knowledgeable dispensing doctor to negotiation team
- Make “what are the implications for dispensing doctors”a question in any negotiation /contract imposition
- Consult Dispensing Doctors on the issues they are facing , then address these in negotiations
- Seek equivalence to community pharmacy contract modifications especially for clinical services
- Agree nothing about us WITHOUT US!

Amanda Doyle letter

Dear Dr West,

Thank you for your letter to NHS England regarding the challenges faced by rural dispensing practices, and the detail you have provided – and please accept my apologies for the significant delay in replying. I have been asked to respond to this on behalf of NHS England.

I understand the concerns you have raised, particularly around reimbursement, remuneration, the use of technology in dispensaries, and the overall sustainability of dispensing practices.

As you will be aware, the recently published 10 Year Health Plan sets out the radical vision to reinvent the NHS and transform patient care, of which dispensing is a key element. As part of the 10 Year Health Plan delivery, including the wider GP contract reform which has been committed to, we will work with stakeholders, including the Dispensing Doctors' Association (DDA), to ensure that dispensing practices are supported appropriately.

While I realise this does not now answer the specific points you have raised, I recognise the challenges you have raised, and these will be considered as we take forward the 10 Year Health Plan.

Yours sincerely,

Dr Amanda Doyle OBE, MRCGP

National Director for Primary Care and Community Services

NHS England

Things to Look Out For

- Incentives for national neighbourhood health program
- New GMS contract or collective action
- Any new financial allocations to GMS/PMS next year
- Response to BMA demands (ARSS funding into core)
- What if any money from treasury for NHS Plan or more taxes on us (like NI)
- Any moves on reimbursement, discount non deducted, fee envelope, dispensing fee
- Recognition from BMA and DH Dispensing Doctors exist!

What to do now (in my opinion)

- IF successful for neighbourhood health program ,proceed with caution
- Protect your managers from extra unfunded work, demand resource!
- Otherwise mount a watching brief and don’t believe all of this will happen
- Most NHS plans fall short !
- Lobby your LMC to get motion to LMC conference on GPC representing us
- Await the implementation chapter!
- Await more details on virtually everything

What to do Now (in My opinion)

- Don’t be afraid to say “no” to ICBs trying to cluster you into “neighbourhoods”
- Ensure your PCN CD represents your practice and Dispensing Doctors and is not just an agent for ICB driven reform
- Resist more attempts to dump clinical or administrative work on you
- (Plan says its going to free you up from bureaucracy)
- Keep your GMS/PMS contract with unlimited liability separate from any cash limited “neighbourhood contract” and don’t expose core contract to any new risks
- Limit your liability and seek legal and financial advice in any new venture or contract

More Realities

- Most NHS budgets will be insufficient to match demand and therefore plan for deficits , who is liable?
- Public Health gets no new funding I can see and remain in Local Authorities, many of which are on verge of bankruptcy (sickness to prevention?)
- So Public health measures through legislation etc
- Potential industrial action ,nurses, resident doctors, ? GPs
- Trusts will not be allowed to produce deficits , so that will mean services cut and risk more cost shifting ,so they will look to neighbourhood contracts to keep funds under their control
- Community Pharmacy still struggling too and most premises designed for dispensing medicines not clinical services

Realities for NHS Plan Implementation

- Workforce ,plan says will train thousands more GPs but only 1000 new speciality training posts and many GPs out of work!
- They are going to bring back the family doctor but encourage GPs to work at larger scale??
- The NHS App is going to be a “GP in your pocket” ,who takes clinical responsibility for that?
- Will AI bring all the savings they expect?
- Can the NHS agree a unified care record ? Who is data controller?

Never Give Up!

You Provider a Great One Stop Shop Service

NHS Plan is blind to you

DDA will open their eyes!

Will BMA though?

Lobby them hard via LMCs

Fairy Tales Don’t Usually Come True!

And that is what I think the “NHS Plan” Is !

DDA will work to give you a happy ending
But for now have a drink on us!