



DISPENSING DOCTORS' ASSOCIATION

Dispensing Practices in England

Addressing The Disparities: A manifesto for change

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**Victory Mill, Priestmans Lane, Thornton-Le-Dale,
Pickering. YO18 7RU**

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1. Summary of Recommendations

The DDA asks MPs to recommend the following actions to ensure the sustainability and parity of dispensing GP practices in England:

- 1. Support dispensing GPs with an emergency stabilisation payment**
- 2. Establish a New Dispensing Contract**
- 3. Fair Baseline Funding Before Reform**
- 4. Implement Reform of Drug Reimbursement Costs**
- 5. Reform the Discount Abatement (Clawback) System**
- 6. Modernise the Dispensing Services Quality Scheme (DSQS)**
- 7. Fund the Electronic Prescription Service in dispensing GPs**
- 8. Create a Digital and Automation Innovation Fund**
- 9. Support Workforce Sustainability and Efficiency**
- 10. Reinstate IT Infrastructure Funding for Dispensing Practices**

2. Key points

- ▶ Dispensing doctors are general practitioners (GPs) who provide a critical, but increasingly fragile, role in delivering primary healthcare to around 10.14 million patients in remote, rural and coastal England.
- ▶ Almost 3.58 million of these patients live remotely, more than 1.6km, from a community pharmacy; at the patient's request dispensing doctors are allowed to dispense the medicines they prescribe for these patients. These practices are the only NHS access point for medicines in many rural areas, ensuring continuity of care for geographically isolated communities.
- ▶ In total, around 7% of all prescription items are dispensed by doctors.
- ▶ The unique benefits of the dispensing doctor service are that it provides access to medicines and general healthcare under one roof.
- ▶ A total network of 1,084 dispensing practices across Great Britain is located as follows:
- ▶ Despite their importance, dispensing practices' costs have risen sharply over the past decade, while dispensing fees have barely changed.
- ▶ Without reform, the continued erosion of dispensing income, combined with exclusion from innovation funding, risks destabilising rural healthcare provision.

A dispensing practice serving 4,000 remote, rural, coastal patients may be responsible for every prescription and repeat medicine within a 20-mile radius — the same workload as an urban practice with two to three pharmacies nearby, but with none of the same infrastructure or funding support.

3. About the DDA

- ▶ The Dispensing Doctors' Association (DDA) represents over 1000 dispensing GP practices across the United Kingdom.
- ▶ The DDA supports 935 dispensing practices, covering 9.54 million registered patients in England. These practices serve remote, rural and coastal communities where population density is too low to sustain a community pharmacy; a patient must live more than 1.6km from the nearest pharmacy to qualify.
- ▶ In these areas, the GP practice provides both clinical care and medicines supply under strict NHS regulations.
- ▶ The DDA works with BMA GPC to advocate for fair funding, contractual reform, and the integration of dispensing into national primary care policy.

935 dispensing practices represent just under 12.5% of all GP practices in England, but serve approximately 9.5 million registered patients — nearly 15 % of English registered patients.

4. What is a Dispensing GP Practice?

- ▶ A dispensing GP practice is a general medical practice with “outline consent and premises approval” to both prescribe and supply medicines directly to its patients, rather than issuing prescriptions for a pharmacy to fill. This model primarily serves remote, rural and coastal populations where patients live more than 1.6 km from a pharmacy, often in areas with limited public transport and long travel distances.
- ▶ Dispensing practices exist in areas where commercial pharmacies are not financially viable and hence provide essential pharmaceutical services to rural patients.
- ▶ This model of care pre-dates the NHS and first began in 1911 – when National Insurance was introduced.
- ▶ Dispensing practices:
 - ▶ Prescribe and dispense medicines on-site under NHS regulation;
 - ▶ Offer medication reviews and patient support;
 - ▶ Manage repeat prescribing safely and efficiently;
 - ▶ Provide continuity of care, often as the only NHS healthcare provider within large catchment areas.
- ▶ Most dispensing practices do not employ pharmacists; instead, they train and supervise qualified dispensers working under strict Standard Operating procedures (SOPs) and GP oversight, ensuring both safety and efficiency.

In many English villages, the dispensing GP surgery can be the only NHS facility within 15-20 miles — meaning without it, patients would need to travel over 30 minutes to access their medicines, often without public transport.

5. How Dispensing Works Financially

- ▶ Dispensing practices purchase medicines from wholesalers and supply them directly to patients. They are reimbursed by the NHS through two mechanisms:
 - ▶ **1. Reimbursement:**
Covers the medicine's cost at the NHS Drug Tariff price. Practices may buy below tariff, but available discounts have reduced sharply in recent years.
 - ▶ **2. Remuneration:**
The dispensing fee — intended to cover staff, overheads, and GP clinical responsibility - historically, 60% of the fee covers operational costs and 40% represents GP remuneration for responsibility and risk.
- ▶ The average English dispensing practice dispenses around 4,000 items per month, with an annual drug spend exceeding £500,000.
All operational, staffing, uniforms, training, compliance, and consumable costs must be met from the dispensing fee, which has not risen in real terms for over a decade.

In April 2012, the dispensing fees ranged from
£1.95-£2.29 per item

In April 2025, the same fee scale ranged from
£2.07-£2.34 per item.

Expenses have more than doubled in that
period, while the dispensing fee has risen by
barely 1–5%.

6. Drug Reimbursement Costs

- ▶ Dispensing practices purchase drugs in the same marketplace as community pharmacies. Practices take deliveries of drugs from the same wholesalers as community pharmacies
- ▶ The DHSC, in negotiation with Community Pharmacy England, has established a completely new system of reimbursement for pharmacies
- ▶ The DHSC published its response, and Impact Assessment, to the 2019 drug reimbursement consultation as long ago as November 2021:
- ▶ *“In the consultation document we recognised that some of the proposals impact either directly or indirectly on others, aside from pharmacy contractors, in the supply chain. This includes manufacturers and wholesalers, and more widely on the NHS, in particular Dispensing Doctors, and also Clinical Commissioning Groups who pay for the cost of prescribed products in their areas.*
- ▶ *As set out in the previous chapter, following the consultation responses, we assessed the impact on dispensing doctors in the final Impact Assessment that has been published alongside this Consultation Response. We received 4 responses to the consultation from dispensing doctors or bodies representing them. We also asked the British Medical Association (BMA) and the Dispensing Doctors’ Association (DDA) to provide information to inform the final impact assessment.*
- ▶ *The detail of the remuneration and reimbursement of dispensing doctors is consulted on as part of the negotiations on the General Medical Services Statement of Financial Entitlements (GMS SFE) with the BMA. The NHS reimbursement prices of drugs and appliances dispensed by dispensing doctors is fixed by the cross-referencing in the GMS SFE to the Drug Tariff. Any change to the reimbursement arrangements for dispensing doctors would therefore need to be addressed through negotiations on the GMS SFE.”*

WE ASK MPs TO:

Request that the DHSC/NHSE implements the recommendations of its own consultation response

7. Dispensing Fee and Erosion of Value

- ▶ In 2012, the dispensing fee ranged from £1.95 to £2.29 per item.
In 2025, it stands at £2.07–£2.34 — an increase of between 1% and 5% over thirteen years.
- ▶ Over the same period:
 - ▶ The National Minimum Wage rose from £6.19 (2012) to £12.21 (2025) — up 97%.
 - ▶ Employer National Insurance rates increased twice, most recently in 2025.
 - ▶ Energy and compliance costs have doubled.
- ▶ If the dispensing fee had risen in line with staffing and overhead costs, it would now average around £3.90 per item — almost double the current rate.
- ▶ This sustained erosion leaves practices under acute financial strain, forcing consideration of staffing reductions, reduced hours, or even handing back dispensing rights.
- ▶ *Example:* For an average site dispensing 7,000 items per month, the 2025 fee shortfall represents a real-terms annual funding loss of over £130,000 compared with 2012 value.

WE ASK MPs TO:

Request that the DHSC/NHSE recalibrates the current dispensing envelope to reflect 2025 market costs before developing any new contractual model.

8. Discount Abatement & Clawback Inequities

- ▶ Dispensing GP practices face persistent inequity through the discount-abatement (clawback) mechanism. This system was created decades ago, when wholesalers and manufacturers offered large purchase discounts to both pharmacies and dispensing doctors. Those discounts have since diminished, but the clawback system has not been modernised.
 - ▶ Community pharmacies face a 5-6% clawback on reimbursed medicines.
 - ▶ Dispensing GPs face a sliding scale that rises to 11.18%, regardless of whether any discount was actually received. Most practices are clawed back the full 11.18%.
- ▶ Two further mechanisms widen this inequality:
 - ▶ **Discount Not Deducted (DND) list:**
Medicines such as insulins, vaccines, and biologics are recognised as not attracting wholesale discount. Pharmacies dispensing these are reimbursed in full and exempt from clawback. Dispensing practices remain subject to the full 11.18% deduction on those same medicines. So far in 2025, over 1,300 medicines have been listed on the DND schedule representing a significant and recurrent loss.
 - ▶ **Concessionary prices:**
When medicine shortages inflate costs, both pharmacies and dispensing GPs can claim a temporary “concessionary” price. However, because these items are automatically placed on the DND list, pharmacies are protected from clawback while dispensing practices still lose the extra 11.18% on a known loss-maker.
- ▶ *Example:* A dispensing GP dispensing £10,000 worth of insulin and vaccines in a month can lose over £1,100 in clawback deductions that a pharmacy would not face.

WE ASK MPs TO:

Request immediate extension of DND protections to dispensing GP practices in England, while reviewing options to abolish the clawback system altogether.

9. Electronic Prescription Service (EPS)

- ▶ The Electronic Prescription Service (EPS) operates in two stages:
 - ▶ **1. Prescription generation and transmission:**
GPs can now send digital prescriptions to the NHS “spine.” This is fully funded for all practices, dispensing and non-dispensing.
 - ▶ **2. Prescription download and dispensing:**
To receive and process these prescriptions, the dispensary needs separate software and hardware capable of downloading the prescription items, generating the labels, and claiming the reimbursement. Without it, prescriptions can be sent to the spine but cannot be downloaded for dispensing or be claimed electronically.
- ▶ Dispensing GP practices must self-fund all the necessary hardware and software.
 - ▶ EPS-ready systems such as Titan cost around £2,500 per branch to install, £250 per month per branch in ongoing fees, plus 4p per dispensed item.
 - ▶ For an average two-branch practice dispensing 7,000 items per month, this equates to set up costs of £5,000 plus over £9,500 annually in running costs — all currently unfunded.
- ▶ Many PMR systems already used by pharmacies are now capable of receiving EPS prescriptions, meaning there is no additional set-up costs.
- ▶ The pharmacy sector also received up to £1,250 per site in EPS setup funding.
- ▶ There is no funding available for comparative payments to dispensing practices.

WE ASK MPs TO:

Recommend that the DHSC/NHSE provides dedicated funding for both the setup and operational costs of EPS for dispensing practices

10. Digital Exclusion and Innovation Gap

- ▶ Community pharmacies across England have benefited from successive waves of digital investment — including robotic dispensing, barcode systems, and 24-hour collection ATMs — improving efficiency, safety, and access for patients.
- ▶ Dispensing GP practices, however, have been excluded from these innovation funds.
Despite providing the same NHS medicines supply service, they must rely on manual processes with no access to capital for automation or infrastructure support.
- ▶ Automation has proven benefits: it reduces dispensing errors, improves workflow, and frees staff time for patient-facing work.
- ▶ Even entry-level systems remain unaffordable.
 - ▶ A small semi-automated robot costs around £35,000–£60,000, while full automation systems exceed £90,000.
 - ▶ Automated prescription collection machines add a further £30,000–£50,000, far beyond what rural practices can fund from static dispensing income.
- ▶ As a result, rural patients continue to face limited collection times and manual service delivery, while urban pharmacies move ahead with digital efficiency.
- ▶ Without access to capital investment, rural dispensing practices cannot modernise alongside community pharmacy, widening the digital divide, entrenching health inequality and potentiating workforce strain in these rural areas.

WE ASK MPs TO:

Recommend that the DHSC/NHSE establish a Digital and Automation Innovation Fund for Dispensing GP Practices, to support investment in:

- Safe automation and robotic dispensing systems
- Secure 24-hour prescription collection units
- Barcode verification and digital stock control tools

11. Modernising the Dispensing Services Quality Scheme (DSQS)

- ▶ The Dispensing Services Quality Scheme (DSQS) was introduced to support safe and high-quality dispensing standards in GP practices, rewarding good governance, staff training, and patient safety audits.
However, the payment has been frozen at £2.58 per patient per year since 2006, with no inflationary uplift for almost two decades.
- ▶ In real terms, that value has eroded by more than 40%, leaving the scheme unable to cover even a fraction of the compliance and training costs it was designed to support.
If DSQS had risen in line with inflation, the payment today would be around £4.47 per patient per year.
- ▶ The requirements placed on dispensing practices to meet the DSQS payment all require investment and staff time and include:
 - ▶ Mandatory audits, controlled drug monitoring, and medicines governance reviews,
 - ▶ Increasing staff training and revalidation requirements,
 - ▶ Drug usage reviews.
- ▶ Each of these adds administrative time and cost.
Dispensing GP practices must fund these requirements entirely from within their dispensing income — income that has itself stagnated.
- ▶ The frozen DSQS payment therefore fails both in fairness and in purpose: it does not reflect modern compliance expectations, nor does it support safe, high-quality dispensing in the way originally intended.

WE ASK MPs TO:

Recommend an immediate uplift of the DSQS payment from £2.58 to £4.47 per patient per year, with a guarantee that it will:

- Be indexed to inflation or DDRB recommendations annually, and
- Include recognition of new governance and safety standards introduced since 2006.

12. Full Recommendations

The DDA asks MPs to recommend the following actions to ensure the sustainability and parity of dispensing GP practices in England:

1. **Stabilisation and Immediate Support**

We ask MPs to request an emergency stabilisation payment for dispensing GP practices — similar to that received by community pharmacies — to protect services while longer-term reforms are implemented.

2. **Establish a New Dispensing Contract**

We ask MPs to request that the DHSC/NHSE develops a new dispensing practice contract, moving from the current item-based model to a capitation-based funding system that reflects rural workload, patient need, and the true costs of safe dispensing.

3. **Fair Baseline Funding Before Reform**

We ask MPs to request that any new capitation model begins from a realistic, uplifted baseline, reflecting 2025 operating costs, staffing levels, and overheads, rather than converting the existing underfunded dispensing fee into a new structure without adjustment.

4. **Implement Reform of Drug Reimbursement Costs**

We ask MPs to request that the DHSC/NHSE implement the recommendations of *its own* consultation to ensure that dispensing practices are treated fairly when purchasing drugs in the marketplace.

5. **Reform the Discount Abatement (Clawback) System**

We ask MPs to request immediate access for dispensing GP practices to Discount Not Deducted (DND) protections, followed by a full review of the clawback system with a view to abolition, ensuring parity with community pharmacy and removing penalties where no discounts are achieved.

13. Full Recommendations

(continued...)

6. **Modernise the Dispensing Services Quality Scheme (DSQS)**

We ask MP to request an uplift of the DSQS payment from £2.58 per patient per year to £4.47, indexed annually to inflation or DDRB recommendations, to accurately reflect the true cost of maintaining safe, compliant dispensing.

7. **Fund EPS Implementation for Dispensing GP Practices**

We ask MPs to recommend full capital and ongoing funding for Electronic Prescription Service (EPS) functionality within dispensing GP systems, enabling parity of access with community pharmacies and ending digital exclusion for rural practices.

8. **Create a Digital and Automation Innovation Fund**

We ask MPs to request that the DHSC/NHSE establish a Digital and Automation Innovation Fund for Dispensing GP Practices, providing targeted investment for automation, barcode verification, and secure 24-hour prescription collection technology to improve efficiency, safety, and patient access.

9. **Support Workforce Sustainability and Efficiency**

We ask MPs to request contractual flexibility that allows longer prescribing intervals and efficiency measures without financial penalty, supporting better use of staff time and improved continuity of care.

10. **Reinstate IT Infrastructure Funding for Dispensing Practices**

We ask MPs to request that IT hardware and software required for dispensing operations should be returned to the core NHS GP IM&T budget, ensuring equitable support with non-dispensing practices and community pharmacies.

14. References

1. **Department of Health & Social Care (2023).** *General Medical Services (GMS) Contract: Statement of Financial Entitlements*. Defines the dispensing fee framework in England & Wales.
2. **Department of Health and Social Care (2012).** *Statement of Financial Entitlements (Amendment Directions) 2012*. Establishes the last negotiated changes to the dispensing fee and payment structure.
3. **NHS Business Services Authority (NHSBSA) (2025).** [Drug Tariff and Dispensing Data for England and Wales](#). Provides current dispensing fee ranges, discount abatement rates, and item volume statistics.
4. **Community Pharmacy England (2025).** [Discount Not Deducted \(DND\) List Update – October 2025](#). Confirms over 700 active DND items and outlines the protection mechanism for pharmacies.
<https://cpe.org.uk>
5. **ABPI (2024).** [Code of Practice for the Pharmaceutical Industry](#). Explains the reduction in manufacturer and wholesaler discounting that has eroded the original rationale for discount abatement.
6. **Community Pharmacy England (2025).** [CPCF arrangements for 2024/25 and 2025/26 announced](#). Details pharmacy funding uplifts of 30% for the sector.
7. **DHSC (2022).** [Community Pharmacy Contractual Framework 5-Year Deal](#). Describes the shift to service-based payments and innovation funding for community pharmacies.
8. **NHS England (2023).** [Securing Excellence in Primary Care \(GP\) Digital Services: the Primary Care \(GP\) Digital Services Operating Model 2021-23](#). Outlines NHS-funded IT for GP practices and notes the exclusion of dispensing systems from central funding.
9. **Community Pharmacy England (2024).** [IT & EPS Funding](#). Confirms EPS funding for pharmacy PMR systems, contrasting with lack of GP dispensing funding.
10. **DDA (Dispensing Doctors' Association) (2024).** [Podcast Series: Dispensing Finance and Fee Structure Explained \(Episode 1\)](#). Explains the 60/40 dispensing income model and real-terms erosion of funding.

15. References

- 11. NHS Employers / DDRB (2012–2025).** *Annual Reports on GP Pay Awards.*
Details annual GP pay recommendations relevant to the 40% remuneration component of dispensing income.
- 12. Office for National Statistics (ONS) (2025).** *Consumer Price Index and Average Earnings Data (2012–2025).*
Used to quantify the real-terms fall in the dispensing fee relative to cost growth.
- 13. DHSC Community Pharmacy Drug Reimbursement Reform (2021)** Details DHSC's expectation that reforms to community pharmacy reimbursement should be implemented for dispensing practice.
<https://www.gov.uk/government/consultations/community-pharmacy-drug-reimbursement-reform/outcome/community-pharmacy-drug-reimbursement-reform-consultation-response>
- 14. DDA Dispensary Services Quality Scheme (2006)** Details DSQS aims & payments structure – last uplifted in 2006.
- 15. NHS Digital (2024).** *Electronic Prescription Service (EPS) Technical and Financial Overview.*
Details implementation costs and funding structures for EPS, showing exclusion of dispensing GP practices.
- 16. DDA (2025).** *Survey of Dispensing GP Practices.* Provides anonymised examples of fee erosion, staffing, impacts, and service risks in rural practices.