A welcome from the DDA Chief Executive Matthew Isom

How is your dispensary business doing at the moment? I have been hearing some stories about a few small practices closing their dispensaries because they claim they are no longer profitable; this really surprises me.

Whilst there is no question that it is much harder to get discounts since some of the larger pharmaceutical companies moved to the DTP (Direct to Pharmacy) business model, there is no reason why a dispensary should not make you money. However, you really do have to focus on your purchasing and scrutinise your business decisions in a way that you perhaps did not do in the recent past. The days of leaving the dispensary or any part of the practice, to run itself are now well and truly over.

Between 2005-06 and 2012-13, dispensing practices have seen a much larger drop in income than has been seen by non-dispensing practice. Much of the fall in dispensing income is due to DTP, but also Category M and the introduction of the Community Pharmacy Contractual Framework. Considerable amounts of money were withdrawn from Category M prior to 2014 in order to ensure that the pharmacies achieved their agreed level of purchase profit. Dispensing practices have no such agreement, but you are linked to the Drug Tariff through the GP contract and the DDA is not consulted about Category M. This is why we are working hard to change the system of drug reimbursement for practices. You can read more about this on page 8.

If you are experiencing difficulties with your dispensary business, please contact the DDA. We can help you. There is no reason why a practice should close its dispensary, other than a community pharmacy application being successful.

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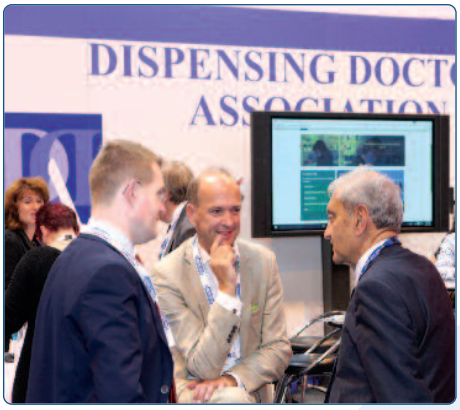
DISPENSING DOCTORS' ASSOCIATION
EDUCATIONAL SUPPLEMENT ONLINE

DDA conference update...



The DDA annual conference goes from strength to strength with its seminar programme for the 2015 event attracting over 775 delegates over the event's two days. Each seminar on average attracted around 86 delegates, representing the whole spectrum of primary healthcare professionals including pharmacists, nurses, GPs (salaried and partners) and practice and dispensary staff.

Popular presentations from the conference included 'Pharmacists working in general practice: the experience of a rural Cornish practice pharmacist', and the CQC's talk on 'Regulating the safe and effective use of medicines'.

Plans for the 2016 Annual Conference are now underway, and this takes place at the NEC, Birmingham on October 19-20, 2016.

We hope to see you there!

Best Practice
19-20 October 2016
Birmingham NEC

To register your place, visit: www.dispensingdoctor.org/conference/

Remove dispensing income - and rural practice will fall over

Small rural practices earn 30-40% less from GMS than urban practices. They need dispensing income to survive and if you pull dispensing income out from rural practices, they will fall over, **DDA chairman, Dr Richard West**, has told GPs in a presentation on the challenges and opportunities in the new dispensing environment.

The Department of Health was pushing forward with its vision for new models of care, and as a result, "money will move in that direction," he told GPs.

But, he said this presented unique challenges for dispensing GPs. He said: "You need to keep your dispensing contract," and he explained that if the contract stops and is replaced by a new contract, the dispensing practice will lose its dispensing rights and it will have to reapply under the 2013 pharmacy services regulations. "These make it very easy for pharmacy to pick off all your patients."

The presentation, which was sponsored by Napp Pharmaceuticals and held in Kent, also discussed the opportunities for dispensing practice of medicines optimisation and pharmacists in general practice. Slides from the presentation are available on DDA Online at:

www.dispensingdoctor.org/news/dda-sets-out-future-challenges-for-dispensing-practice/

Q4 category M reductions wipe £45m off reimbursement prices

Dispensing practices are warned to take a close look at category M reimbursement prices from January; the final quarter of 2015-16 sees 94% of prices fall – and one in three by over 30%

To view the full January 2015 price changes, visit DDA Online at: **www.dispensingdoctor.org/resources/dispensary-management-zone/category-m-updates/**

Pharmacy contract negotiator PSNC has explained that the aim is to ensure the delivery of the agreed £800 million in margin during 2015-16. By returning £15 million per month to the Treasury - equivalent to £45 million for the quarter to March, 2016 - contractors will reduce the likelihood of any subsequent 'shock' reductions in reimbursement prices.

Despite this pre-emptive strike, it is still possible that further reductions to reimbursement prices will be necessary during 2016-17, to achieve the agreed purchase margin delivery for 2015-16: the Q4 adjustment follows two previous Category M quarterly adjustments that have proved, on balance, favourable to dispensing contractors in terms of the amount of purchase profits delivered.

Additions to Category M	Size	Dec-15	Jan-16	Price Change	% price Change
Acetazolamide 250mg tablets	112	£86.50	£77.45	-£9.05	-10%
Brinzolamide 10mg/ml eye drops	5ml	£9.23	£5.09	-£4.14	-45%
Lacidipine 2mg tablets	28	£3.98	£3.19	-£0.79	-20%
Lacidipine 4mg tablets	28	£4.07	£3.23	-£0.84	-21%
Nebivolol 2.5mg tablets	28	£69.85	£47.34	-£22.51	-32%
Tizanidine 2mg tablets	120	£27.97	£3.67	-£24.30	-87%

Biggest price drops	Size	Oct-15	Jan-16	Price Change	% price Change
Sevelamer 800mg tablets	180	£135.81	£104.02	£31.79	-23%
Aripiprazole 5mg tablets	28	£43.99	£20.63	£23.36	-53%
Aripiprazole 15mg tablets	28	£43.37	£20.24	£23.13	-53%
Aripiprazole 10mg tablets	28	£43.81	£20.81	£23.00	-52%
Eplerenone 50mg tablets	28	£33.58	£22.66	£10.92	-33%

Wavedata price trend analysis

Latest analysis for purchasing in generics and parallel imports shows that dispensing doctors have been able to reduce their buying bill; they have significantly closed the gap between the PI prices paid by GPs and pharmacists, and they consistently achieve far more favourable generics prices.

During December, the main headline price faller was pregabalin caps, five lines of which fell to around a quarter of the February 2015 launch price. Other key fallers include oxycodone, and tramadol SR tabs. Key price risers include two packs each of clonazepam tabs, and diamorphine hydrochloride powder for solution for suspension S/F 120mg/5ml.

Fallers

The average price of cimetidine tabs 200mg x60 fell dramatically as a number of very high prices disappeared from the market. The best dispensing GP prices available in December came from Lexon and Eclipse.

Dispensing GPs mind the PI gap but steam ahead with generics buying

ONLINE EXCLUSIVE!

Isosorbide mononitrate XL tabs 40mg x28 dropped in price after the disappearance of a number of very high prices. The best offers below £6.00 to dispensing doctors in December were from Lexon, Mawdsleys and AAH. Pharmacists saw offers below £6.00 from Cavendish, Lexon, Eclipse, OTC Direct, Mawdsleys, AAH, Alliance, Trident and Chemilines.

The best prices for nifedipine MR tabs 20mg x56 – at less than £3.00 and representing a 60% fall - were available to dispensing doctors from AAH and Lexon. Pharmacists also saw low prices from AAH, Lexon, Trident, Chemilines and Numark.

Risers

The prices for celiprolol tabs 400mg x28 during December doubled as all suppliers to pharmacy and dispensing practice increased their prices. This was due to the NCSO price of £39.65, which was current in both November and December. The best prices available to either customer were from Lexon, although good offers were also published by Ethigen.

Simple Eye Ointment 4g rose in price by 105% as some of the low-priced November offers disappeared from the market. Low prices below £3.00 were still available to dispensing doctors from AAH, and to pharmacists from Ethigen.

Many of the low-priced November offers for acarbose tabs 50mg x90 disappeared in December, leaving only Lexon offering stock at below £4.00 to dispensing doctors. However, pharmacists saw good priced offers below £4.00 from Lexon, Ethigen, Numark and Phoenix.

Brought to you exclusively by the Dispensing Doctors' Association

Be the first to see it! Full analysis of pricing trends during January will be available to DDA members in the first week of February – but only on DDA Online. The full December purchase price analysis data is now available to DDA members in the Dispensary Management Zone of DDA Online at: **http://www.dispensingdoctor.org/resources/dispensary-management-zone/monthly-purchase-price-analysis/**

The implications of hub and spoke dispensing

There is a growing political will to see greater use made of centralised dispensing and legislative changes in 2016 are planned to increase its development.

A Robotik Technology MDS compliance aid robot in use at Meddyg Care Porthmadog

Under existing legislation, dispensing and supply of dispensed medicines has to be done by the same legal entity. As hub and spoke (centralised) dispensing efficiency increases with greater volume it is something that the larger pharmacy multiples have adopted, although some smaller chains have also introduced repeat dispensing hubs into their own business, typically to manage the repeat dispensing of compliance aids.

Regulatory changes in 2016, however, will allow more than one legal entity to be involved in the dispensing process, paving the way for buying groups or federations of businesses and even, member organisations, to set up dispensing hubs on behalf of members, and across professional boundaries.

This change is intended to allow all spoke pharmacies to significantly free up workload so that pharmacists are able to spend more time with patients to help reduce GP work-load. There are possibly accuracy gains as well from use of automation. However, fears have been raised that increased use of hub and spoke may lead to a reduction in dispensing fees, and estimates have suggested that cuts could run into hundreds of million Pounds – and that is before the fee is shared between the hub and its spokes.

Department of Health estimates suggest that two thirds of dispensing volume could be dealt with by hub and spoke, but the large pharmacy multiples, whose experience of hub and spoke goes back to 2008, question the potential cost savings and benefits of hub and spoke posited by the Department of Health.

Among the confounding factors are the practicalities of fridge lines and cold chain monitoring, as well as controlled drugs, the potential effect of the Falsified Medicines Directive, and of reducing dispensing fees on pharmacy viability – which could see minor ailment w orkload transfer back to GPs and other NHS services.

Many concerns have already been raised about hub and spoke dispensing – and many of these will be shared by dispensing practices and independent pharmacies; a chief concern is the potential of hub and spoke dispensing to encourage direct to patient supply – which has the effect of reducing opportunities for clinical and medicines optimisation advice. Business concerns will include reducing current dispensing fees, and the corresponding impact on the wider service proposition – now and in the future. There is also the potential for dispensing patients to opt to use non GP-owned hub dispensing service, further reducing dispensing fee income. If hub services gain excessive market share, they may also be able to impose unfavourable trading terms on the spoke operation.

With the Department of Health believing two thirds of dispensing is suited to hub and spoke, and with further automation of the system, it is easy to see why there are concerns that the Department of Health could insist on a cut in the dispensing fee to reflect reduced human involvement; even a 20p cut in the dispensing fee would equate to a £200 million reduction in dispensing fees across England.

In addition, the dispensing fee would be split further between the hub and the spoke.

Small contractors, particularly those in very remote locations may also fear the effect on their wholesalers' business terms if dispensary stocks are significantly reduced – although wholesalers say they will retain a role as a 'stock room' for practices.

Since Pharmacy Voice advocated a freeing up of hub and spoke legislation in April 2014 to level the playing field for all pharmacies, the collective view of pharmacy has become increasingly less well disposed towards the system. PSNC recently described large scale hub and spoke models in the UK as untested, and the business viability of this innovation as uncertain. It is also unaware of the potential impact of the model on GPs and other services.

The pharmacy sector knows that it cannot just say no to the national departments of health so it has to propose a viable alternative that will satisfy health ministers and civil servants.

Dispensing doctors will be affected so the DDA is getting involved in the discussions. Whether the sector as a whole can formulate a shared policy on hub and spoke, or whether the multiples and the independents adopt different stances is still under consideration.

The full version of this feature is available to DDA members from the DDA website at:

http://www.dispensingdoctor.org/news/hub-and-spoke-dispensing-what-it-means-for-you/

Dispenser Education Modules: Test your knowledge

DDA Dispenser Education Module (DEM) training is designed to provide practice dispensary staff with information to improve the way patients manage their conditions. Available free and exclusively to DDA members, each DDA DEM includes various activities and multiple choice questions to help dispensers put the theory of their learning into practice, and to help staff identify any areas needing a quick recap. DDA Members can find activities and questions relating to this DEM on anxiety in the DEM library, located on the DDA Website at: **www.dispensingdoctor.org/resources/clinical-zone/dispenser-education-modules/**

Photodisc

Few can be unfamiliar with that sense of panic that takes hold when faced with a stressful situation such as a job interview or exam. But for some, the feeling is ever-present, and makes it very difficult to cope with day-to day life. This is generalised anxiety disorder, a health condition poorly understood with sufferers frequently dismissed as being "stress heads" or similar.

Aims

By the end of this article, you will:

- know what generalised anxiety disorder is, including the symptoms and predisposing factors
- understand how GAD is diagnosed
- have an appreciation of the treatment options available
- be able to advise GAD sufferers on steps they can take to better manage their condition
- be aware of what to do if you come across someone having a panic attack.

What is anxiety and when does it become a problem?

Everyone gets anxious from time to time, and there is a reason for it: those butterflies felt in the tummy are actually the adrenal glands kicking out the adrenaline needed by the body to prepare for action, and by the mind to stay focused on the task in hand.

But going through life with that sense of panic almost all the time – as is the case in generalised anxiety disorder (GAD) – is far from constructive; in fact to sufferers and their close friends and family, it can feel suffocating. Getting the simplest tasks done becomes incredibly difficult, and while many GAD sufferers know that they are fretting over things that don't really matter, being aware that there is an issue without feeling able to control it only adds to the stress.

In GAD, the physical feelings of anxiety – which can include dizziness, shaking, breathlessness, nausea, sweating, heart palpitations, muscle tension, insomnia and disturbed sleep – are accompanied by psychological symptoms, such as restlessness, concentration difficulties, irritability and feeling tired. It is fair to say that many of the manifestations of GAD exacerbate each other.

While GAD can affect anyone, there are some individuals who are more likely to succumb to the condition: those with a first degree relative who is a sufferer, patients with a chronic or painful disease such as arthritis or who have a substance dependence issue, victims of child or domestic abuse, and anyone under a more general source of stress such as having money troubles or being out of work. Gender and age also play a part, with women more likely than men to be diagnosed with GAD, and incidence peaking between 35 and 55 years of age.

It is difficult to put a figure on how many people have GAD, because, like many mental health disorders, sufferers have a tendency to try and battle through alone - rather than seeking help as they would for a complaint with predominantly physical symptoms, eg. a skin condition. In the UK, an estimated 4-5 per cent of adults have

GAD, though this number may well be higher.

Diagnosing depression

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders classification system – usually referred to as DSM-IV – is the tool recommended by the National Institute for Health and Care Excellence (Nice) for diagnosing GAD. Patients should have two core symptoms, plus three of six additional symptoms:

Core symptoms

- excessive anxiety about a range of events for the majority of at least six months
- difficulty controlling the feeling.

Additional symptoms

- tension
- restlessness
- tiring easily
- concentration difficulties
- irritability
- muscle tension
- sleeping problems.

Questionnaires are frequently used to gauge how someone is feeling, most commonly the GAD-7 pro-forma. However, the Hospital Anxiety and Depression Scale (HADS) may be used instead if the patient appears to be suffering depression or another concurrent mental health problem. These protocols not only enable diagnosis of the condition itself and also its severity, though the latter is also influenced by the impact of the symptoms, for example, if they are preventing the patient from going to work or seeing other people.

The patient's medical and personal history will also be taken into account, and blood tests may be conducted to rule out conditions that can have a similar presentation, for example, anaemia or an overactive thyroid gland. Suicide risk should also be assessed, as the chance of someone ending their own life or contemplating doing so is significantly higher in GAD patients than in the general population.

Drug treatment

Assuming any underlying or co-existing conditions have been tackled – for there is little point in trying to treat anxiety symptoms if the anxiety stems from another cause – GAD is managed in a stepwise manner.

All known and suspected cases of GAD should be identified, assessed and monitored, and patients educated about the condition and its treatment options. Self-help measures should be tried, namely:

- Avoiding triggers, both situational and incidental, such as caffeine, alcohol and smoking.
- Eating a healthy diet that is low in salt and sugar.
- Taking regular exercise to encourage physical and mental wellbeing.
- Practising relaxation techniques.
- If possible, stopping medication that lists anxiety as a possible side effect such as decongestants and corticosteroids.

If patients with GAD do not feel their symptoms have improved after trying the above measures, a low intensity psychological intervention should be tried. This involves either using self-help resources, which can be guided or non-facilitated, or attending a support group course. Whichever approach is chosen should be based on the principles of cognitive behavioural therapy.

For individuals who have still not responded or who have GAD symptoms that are having a significant impact on their everyday life, medication or a higher intensity psychological intervention is recommended. The drug of first choice is usually sertraline, though escitalopram or paroxetine may be used instead. For patients in whom a selective serotonin reuptake inhibitor cannot be used, duloxetine or venlafaxine may be tried, or pregabalin if none of the medicines already mentioned are suitable. Therapies that can be tried are weekly CBT or applied relaxation sessions for around three months in total.

Benzodiazepines are sometimes referred to as "anxiolytics" but due to the risk of dependence should only be used in individuals with severe and disabling GAD, and even then only for two to four weeks at most.

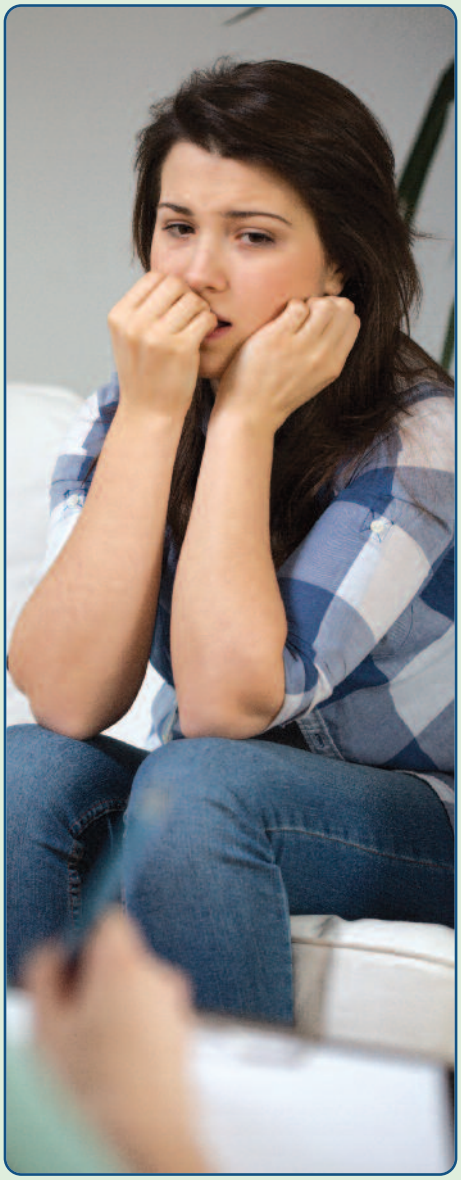
Highly specialist treatment is reserved for GAD patients with symptoms that do not respond to all other measures and who are showing signs of functional impairment such as self-neglect or are at risk of self-harm. These patients usually require complex treatment regimens involving both psychological interventions and medication, and requiring support from a range of healthcare professional and settings, including hospitals and crisis teams.

When dealing with patients with GAD, it is important to adopt a tone that doesn't make them feel judged. The needs of anyone involved in their care should also be taken into consideration, as the toll of looking after someone with a mental or physical health condition can be considerable.

Panic attacks

One of the most acute – and frightening – aspects of anxiety is panic attacks. These can happen to anyone and at any time, sometimes without warning. For the person it is happening to, it can be absolutely terrifying; the brain feels simultaneously overwhelmed and like it is shutting down, while the body frantically does everything it can to make things right.

One of the most alarming aspects of a panic attack is the sudden increase in breathing that often takes place. Keeping calm and trying to slow this down can make a big difference to other symptoms. Panic attacks are usually harmless but if they happen regularly, the individual should seek help as they may be suffering from panic disorder.



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Anxiety disorders can affect people of all ages

Dispenser Education Modules: Test your knowledge

Each DDA DEM includes various activities and multiple choice questions to help dispensers put the theory of their learning into practice, and to help staff identify any areas needing a quick recap.

Activities and questions relating to this DEM on handling controlled drugs (updated December 2015) can be found on the DDA Website, DDA Online at: **www.dispensingdoctor.org/resources/clinical-zone/dispenser-education-modules/**

Dispenser Education

Module 8

Photodisc

Handling controlled drugs – 2015 update

You might consider prescriptions for controlled drugs a hassle from a dispensing point of view, but they aren't going to disappear anytime soon. In 2013, for example, over 3.5 million prescriptions for morphine were dispensed in the community in England – including by dispensing doctor practices – representing a rise of nearly 12 per cent on the previous year. The trend was the same for oxycodone, buprenorphine and tramadol.

Aims

By the end of this article, you will:

- Understand why CDs require special handling, and know the different Schedules that they fall into.
- Know what to do in terms of ordering, storing and dealing with prescriptions for CDs.
- Fully grasp the recordkeeping requirements for CDs.

What are controlled drugs and why are they special?

Controlled drugs – often referred to as CDs – are so-called because they are subject to stricter legal controls than other medicines. This is because these drugs are more likely to be obtained illegally, be misused and cause harm.

The level of control that is applied to a certain substance is dependent on the schedule it is in:

- Schedule 1 (CD Licence POM) drugs are generally considered to have no therapeutic use, for example, hallucinogenic drugs such as LSD, ecstasy and related substances, and cannabis.
- Schedule 2 (CD POM) drugs include opiates such as morphine, diamorphine (also known as heroin), methadone, oxycodone and pethidine, amphetamines, quinalbarbitone and ketamine. Only certain groups of people are allowed to obtain, possess and supply these drugs assuming particular conditions are met.
- Schedule 3 (CD No Reg. (Register) POM) drugs are generally considered to be less harmful and less liable to misuse than the substances in Schedule 2, so are subject to less stringent controls. Examples include buprenorphine, temazepam, midazolam, phenobarbital and tramadol.
- Schedule 4 is split into two parts:
  - Part 1 drugs (CD Benz POM) are mostly benzodiazepines such as diazepam, and the Z drugs zopiclone, zaleplon and zolpidem.
  - Part II drugs (CD Anab POM) includes most of the anabolic and androgenic steroids (eg, nandrolone, testosterone), the adrenoceptor stimulant clenbutrol and growth hormones.
- Schedule 5 (CD Inv. (Invoice) POM or CD Inv. P) drugs are preparations of CDs such as codeine and morphine that are in low enough strengths as to be considered safe enough to be exempt from full control. Dispensing doctors – when acting in their professional capacity – are among the groups who are allowed to obtain, possess and supply CDs, provided they fulfil all the legal requirements that apply.

Employed staff can have certain functions delegated to them, though the dispensing doctor remains accountable for everything that happens. In practice this means that dispensary staff should ask the dispensing doctor to check orders, prescriptions and dispensed items before processing them. Patients can lawfully possess CDs, as long as they have been prescribed for them by someone who is legally allowed to do so.

Each CD schedule has different requirements relating to storage, prescribing and recordkeeping, and sometimes there are even differences between drugs in the same schedule. The rest of this module outlines these characteristics, which are described in detail in several pieces of legislation, including the 1971 Misuse of Drugs Act, the 1973 Safe Custody Regulations, the 2001 Misuse of Drugs Regulations and the 2006 Health Act.

Ordering CDs

In order to obtain stocks of Schedule 2 and 3 CDs, a written requisition must be made. There are standardised forms for this purpose – in England, the FP10CDF, in Wales the WP10CDF and in Scotland the GP10A for NHS supplies and the CDRF for private supplies, all of which can be obtained from the local primary care organisation. Use of these forms, and a statement of authority from your GPs, including when obtaining supplies from wholesalers, becomes mandatory from November 30, 2015.

Faxed or photocopied requisitions are not allowed, though in an emergency a doctor can be supplied with a Schedule 2 or 3 CD on the understanding that a requisition will be supplied within 24 hours. Dispensing doctors (and their staff) are not allowed to supply CDs against a requisition, unless they have a wholesaler's licence, as this form of supply is considered wholesale dealing. Once a CD arrives in the dispensary, it must be checked and entered in the CD register within 24 hours if records are required to be kept. This task can be delegated but the dispensing doctor remains accountable. Invoices for Schedule 3 and 5 CD orders must be retained for two years. Further information on using and purchasing CD registers is given below.

Storing CDs

All Schedule 2 CDs except quinalbarbitone, and several Schedule 3 CDs, are subject to safe custody requirements, which means that they must be stored in a receptacle – usually a cabinet, but sometimes a room – that is built and installed to certain specifications. Only a person authorised to possess the CDs (for example, a dispensing doctor) is allowed to access the locked receptacle, or someone that person has authorised access to (for example, a dispenser). One designated person should have overall responsibility for the keys, which should be kept separately to the receptacle, and this person should know the whereabouts of the keys at all time. In practice, this means that keys are usually logged in and out using a designated book.

CD prescriptions

Certain requirements apply to all items that are prescribed, but prescriptions for Schedule 2 and 3 CDs are subject to additional conditions. From the top of a prescription form and working down, these are:

- The patient's name and address must be clearly stated. "No fixed abode" or "NFA" is acceptable if the individual is homeless, but PO boxes are not.
- The drug dose and formulation must be stated, but the strength only needs writing if more than one is available for that particular product.
- The total quantity has to be written in both words and figures, and be unambiguous. No more than 30 days' supply can be prescribed – including for Schedule 4 CDs – unless there are sound clinical reasons for prescribing more.
- If the prescription needs to be supplied in instalments, it must state the amount of medicine to be supplied per instalment and the interval between each supply. Dental prescriptions should bear the words "for dental use only". Repeatable prescriptions are not allowed.
- The prescription must be signed by the prescriber, and although the name may differ to the signatory, the address must be correct and be within the UK. Electronic signatures are not acceptable. CD prescriptions should only be dispensed if the dispenser either recognises the signature or has checked it is genuine.
- The prescription must be dated and be presented for dispensing within 28 days of being written. This period of validity also applies to Schedule 4 CDs and any owings that may arise. If there is more than one date on a prescription – as may be the case for an instalment prescription – the later date is taken as the start of the 28 day period.

Private prescriptions for Schedule 2 and 3 CDs are subject to the same requirements as those written on the NHS, and must be written on a standardised form (FP10PCD in England, PPCD(I) in Scotland and WP10PCD in Wales). They must also include the prescriber's identification number, which is issued by the local primary care organisation and is different to the prescriber's professional registration number.

When a supply is made against a CD prescription, the form must be promptly marked with date of dispensing. For instalment prescriptions, the prescription must be dated every time a supply is made. When a CD supply is collected, dispenser must ascertain whether it is by the patient, a representative or healthcare professional, asking for evidence of identification if necessary, and requesting them to sign in a designated space on the back of the prescription form.

Drug misuse patients who use a representative to collect their CD must supply a letter of authorisation, which needs to name the representative and state the fact that they are authorised by the patient to make the collection. This has to happen every time a representative collects on a drug misuser's behalf, and they must provide identification to the person making the supply.

Record-keeping

All Schedule 2 CDs going in or out of a dispensary have to be recorded in a register, which may be paper or electronic. Paper registers are split so that different drugs, strengths and formulations are kept in separate sections. Electronic registers must be printable and auditable, and adequately backed up. In all cases, the register must be kept in the dispensary, retained for two years from the date of the last entry, and be made available for inspection upon request. Paper CD Registers, formatted to accommodate one drug per Register, are available from the DDA, and practices should see the DDA Website, **www.dispensingdoctor.org**, for details of how to purchase this useful item of dispensary stationery.

Entries must be made chronologically and promptly, be written as to be indelible, and cannot be altered, other than corrections being made by means of footnotes. If a full quantity cannot be dispense, an entry must be made for every supply, for example, for the initial dispensing and then for the owed amount.

Entries must state:

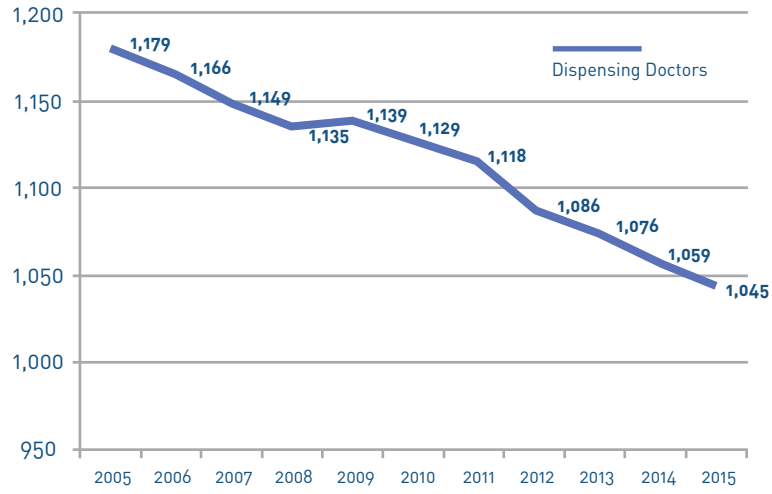
- The date
- Details of authority to possess, eg. prescriber's details
- Quantity supplied
- Details of person collecting, eg. patient, representative, healthcare professional (in which case the name and address must be recorded)
- Whether proof of identity was requested and provided.

Running balances should also be kept, in order that discrepancies are identified as quickly as possible. In practice, this means checking the amount of stock at regular intervals – usually weekly – and it is sensible to have a quick visual check every time a CD is dispensed.

Tough times for dispensing

Data published by the NHSBA shows that during the year to April 2015 there was a reduction of 14 dispensing practices in England, and a 40,000 fall in number of dispensing patients. However, the number of medical patients per practice continues to rise – by 50,000 since 2014.

Dispensing Doctors Decrease



These figures reflect the challenges of providing medical services to increasing numbers of medical patients in rural areas, despite reducing cross subsidy from dispensing income.

Among the influences on the number of dispensing practices in England will be amalgamations by GPs into super practices and other 'at-scale' models of practice. However, reductions in the number of dispensing patients point more to closures or losses of dispensing patients to pharmacies.

Pharmacy openings

Against the background of appalling NHS finances, there has been a significant decline in GP income. And, while dispensing GPs earn more than their non-dispensing colleagues, during the seven years of 2005-06 and 2012-13, dispensing doctor income fell by 11.28 per cent, compared to 6.83% fall for non-dispensing GPs.

Income before tax for dispensing GPs has also decreased every year since its peak in 2005-06, decreasing 11.3 per cent since then, while income before tax for non-dispensing GPs has decreased by less. A contributory factor is that dispensing GP expenses are rising at a faster rate than their gross incomes, and that compared to non-dispensing GPs, dispensing GPs spend more of their gross earnings on expenses. Areas of higher expenditure in dispensing practice include: employee, office and car/travel, as well as drugs.

North of the border, trading conditions in Scotland are equally poor. In 2014-15, dispensing practices have seen dispensing pay fall by an average of just under £9,500 per practice, and as a result of the financial hardships, 10 per cent more dispensing practices are now under Board control - contributing to the £1.4 million rise in the costs of these practices to the NHS, compared to a year earlier.

Any dispensing practice considering amalgamation should seek advice on the effect of amalgamation on their dispensing list. Members can contact the DDA Office for advice, email:

office@dispensingdoctor.org

Overall, income from dispensing in Scotland declined by almost £775,000 during 2014-15, or an average of £9,427 per practice. In 2014-15, average dispensing income per dispensing practice in Scotland stood at £216,609.19, compared with £226,036.83 in 2013-14.

Pharmacy openings

Recent NHS statistics on the number of pharmacy applications in England's rural areas paint a picture of increasing stability, with the number of applications to controlled areas during 2014-15 falling by over 44 per cent compared to 2013-14– and fewer than one in three was successful. The report, General Pharmaceutical Services. England 2005/06 to 2014/15, shows that in 2014-15 in England, there were 21 applications for new and additional pharmacies in rural (controlled) locations of which six were successful (28.5%).

This compares to applications made under the now defunct necessary or desirable test, when in 2011-12, 70 per cent (107) of 153 applications made to controlled areas were successful. This will be welcome news in Wales, where PNA based control of entry is being debated in the Welsh Assembly and where trend data for pharmacy applications shows increasing interest in rural areas; in 2012-13, there were no applications to controlled areas, while in 2013-14, controlled area applications represented over one in four applications (5/22).

At September 2015, there were 82 dispensing GP practices in Wales, a drop of two on December 2014. GP data shows that the average dispensing list size in Wales is 2,368 out of an average total practice patient list size of 6,132. The average dispensing practice has four GPs.

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