A welcome from the DDA Chief Executive Matthew Isom

This is the latest DDA education supplement in association with Actavis.

I am writing this following the 'leave' vote in the EU referendum. We often hear talk of 'historic' moments in history, but this is truly one of them.

Despite the rhetoric of the 'remain' campaigners, it is unlikely that we will see much change in the world of dispensing doctors and the broader pharmaceutical services industry. In or out of the EU, the global market place still exists and there is no sign that any of the current challenges affecting us all will change.

A large part of my work at the moment is representing you at meetings with the Department of Health and the MHRA about the implementation of something called the Falsified Medicines Directive (FMD). This is a piece of EU legislation and it will affect all nations trading in the EU. I have asked the question about what happens now we have voted to leave, and I have been told that we will have to carry on implementing the legislation, as it will largely be a condition of the UK trading with the EU in the future.

Another example of 'business as usual' is the Government's stated intention to continue to remove funding from the community pharmacy contract that was announced last December, and which could yet affect dispensing doctors. The referendum campaign has put a lot of Government policy on hold, but it will be back on track now the referendum is over. The DDA Conference takes place at the Best Practice Show on October 19-20 at the NEC, and this is your chance to stay fully informed of what promise to be fast-moving events. Don't delay, sign up today!

http://www.bestpracticeshow.co.uk/dda

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DISPENSING DOCTORS' ASSOCIATION
EDUCATIONAL SUPPLEMENT ONLINE
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'Dealing with Demand'

DDA annual conference open for registration

Visit the DDA 2016 Conference registration page now, while places remain.

As the conference programme finalises, the DDA is delighted to be able to confirm speakers including the CQC and a CQC inspected practice rated outstanding with first hand tips and hints to share. The DDA Board will also share advice on dispensary profitability and an update on the Five Year Forward View – of which (at October) almost three years remain.

Martin Sawer from the Healthcare Distribution Association UK (formerly the British Association of Pharmaceutical Wholesalers) will also speak on the implications for dispensing practices of the Falsified Medicines Directive.

As well as the packed conference programme, the DDA 2016 conference will offer a free drinks networking session to conclude the first day of the conference, open to DDA members and guests invited by the DDA Board. Visit the DDA conference stand at the NEC to receive your invitation.

The DDA is delighted to be again holding its annual conference alongside the 2016 Best Practice and Best Practice in Nursing conferences and exhibition, taking place this year at the NEC, Birmingham, on October 19-20, 2016.

Visit the DDA's website,
www.dispensingdoctor.org/conference

We hope to see you there!

Best Practice
19-20 October 2016
Birmingham NEC

DDA represents dispensing GPs at hub and spoke discussion table

Ensuring a level playing field for dispensing practices is a key aim for the DDA, which will contribute to a new hub and spoke stakeholder group meeting from July, 2016.

The group has been set up following concerns about the implementation of hub and spoke dispensing raised during a recent Department of Health consultation. These have forced the DH to abandon plans to implement hub and spoke dispensing from October 1, 2016.

According to the DH, consultation responses demonstrated general support for the principle of hub and spoke dispensing across legal entities, but concerns about implementation, for example, how patient consent, data protection and liability will work across legal entities.

In its consultation response, the DDA warns that wholesalers could increase delivery prices if hub and spoke dispensing becomes more common, and this will require extra funding for dispensing practices. DDA chief executive officer Matthew Isom also said that legislation must not discriminate against rural patients.

Other concerns relate to the effect on the availability of medicines to patients in urgent situations and of providing tailored medicines advice. The response also reminds the DH of the documented earlier problems affecting supplies by Pharmacy 2U.

Two category M adjustments in two months for dispensing GPs

The July (Q2) category M adjustment offered a further but much more measured 'tweak' compared to the much more significant extraordinary adjustment to reimbursement prices seen in June.

To view the full July 2016 price changes, visit DDA Online at: **www.dispensingdoctor.org/resources/dispensary-management-zone/category-m-updates/**

In the July adjustment:

- four products are added: fusidic acid 2% cream 309g and 100g; glyceryl trinitrate 400micrograms/dose pump sublingual spray 100 and 200 dose
- carbamazepine 200mg tablets x28 is deleted
- 10 products are reduced in price by at least 50 per cent
- 12 products are increased in price by at least 50 per cent
- 33 products see a price rise of at least £1
- 43 products see a price decrease of at least £1.

The full extent of the June Category M price adjustments saw all 596 products down in price, by an average of 10%.

Of the fallers, 21 fell more than £2 in price, and 117 by at least 50p.

The changes represent a reduction to generic medicine reimbursement prices (Category M) for June to September 2016 worth £12 mllion per month, equivalent to £48m for the four-month period.

For dispensing practices, which account for around 7 per cent of dispensing volume, this will equate to a monthly cut of £840,000 for the period, or a total £3.36m drop in reimbursement.

The reductions are being made by DH in response to the preliminary findings of the 2015/16 medicines margin survey. The intention is to reclaim excess margin that it believes was delivered to contractors in 2015/16 above the agreed allowed £800m. PSNC accepts that margin levels were high during the period, but has not agreed to the reduction.

DDA members were advised to check their stock holdings, in light of the planned reductions in reimbursement.

April – July Category M analysis

Drug	April £	June £	July £	% change April-July
Lamotrigine 5mg dispersible tablets sugar free x28	2.68	2.42	5.58	108%
Loratadine 10mg tablets x30	0.95	0.86	1.88	98%
Candesartan 2mg tablets x7	1.13	1.02	2.16	91%
Lamotrigine 100mg dispersible tablets sugar free x56	2.38	2.15	4.28	80%
Trimethoprim 200mg tablets x6	1.14	1.03	1.82	60%
Lisinopril 20mg / Hydrochlorothiazide 12.5mg tablets x 28	7.70	6.94	2.00	-135%
Captopril 25mg tablets x56	3.69	3.32	1.05	-140%
Trimethoprim 200mg tablets x14	2.66	2.4	0.78	-141%
Glyceryl trinitrate 500microgram sublingual tablets x 100	10.57	9.53	3.79	-156%
Ibandronic acid 50mg tablets x 28	14.97	13.49	6.28	-172%

Wavedata price trend analysis

Dispensing GPs smile at generics' price offers

ONLINE EXCLUSIVE!

Generics prices have been kind to dispensing GPs this Spring. In May GP generics prices were on average 24 per cent cheaper than those available to pharmacies, and PIs 2 per cent.

Fallers

The dispensing GP naproxen tabs 500mg x28 price offer fell on average by 70 per cent in June as the English drug tariff fell to £1.22 and suppliers reduced prices to follow suit. June also saw a 40 per cent reduction in the prices of levofloxacin tabs 250mg x5, led by Actavis.

Reduction in the Drug Tariffs' prices for pioglitazone tabs 15mg x28 prompted an average 34 per cent reduction in purchase prices.

Noteworthy offers on all fallers were available from AAH, Actavis, Beta, Cavendish, Chemilines, DE, Eclipse, Elite, Ethigen OTC Direct, Mawdsleys, Teva, Northwest Healthcare, Numark, Teva and Zecare.

Risers

The average price of isosorbide mononitrate tabs 20mg x56 rose in June by 1879 per cent as an NCSO concession price was applied, and the number of market offers tracked by Wavedata reduced by almost a quarter.

Ropinirole tabs 5mg x84 rose by an average 1772 per cent in June due to the effect of one supplier confusing the market with an massively inflated out of stock price of well over £100.

Similarly inflated prices were also seen for ropinirole tabs 2mg x84. However the rest of the supplier market failed to take the bait and good prices of below £5.00 were still on offer. Suppliers with good prices on all risers include: Alliance, Beta, DE, Eclipse, Ethigen, Islestone, Lexon, OTC Direct, Mawdsleys and Pharmaceutical Direct.

Brought to you exclusively by the Dispensing Doctors' Association

Be the first to see it! Full analysis of pricing trends during July will be available to DDA members in the first week of August – only on DDA Online. The full June 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/**

How to protect your dispensing list

Contractual obligations to ramp up the EPS put pressure on dispensing practices' dispensing lists. Here's how to protect your patients' choices

Dispensing practices in England are advised to consider how to protect their dispensing lists from 'leakage' caused by inadvertent pharmacy nominations, the DDA has urged as the EPS moves into its "full functionality" phase.

Proposals to take the Electronic Prescription Service (EPS) into its next phase will see mandatory nominations removed, although pharmacists are advised to still give patients "the opportunity to benefit from using nomination".

In its new phase most prescriptions will be sent via EPS by default, although paper prescriptions will still be used, for example, when requested by the patient, or for drugs not mapped to the dm+d coding system.

Patients using the EPS will not need to make a nomination, although existing nominations will remain valid and further nominations for appropriate patients can continue to be set. Those patients who use the EPS but who do not set a nomination will use a prescription token to allow their chosen EPS dispensary to access the electronic prescription for dispensing.

Dispensing practices in England are reminded that dispensing patients may not be able to use the EPS until April 2017, as an EPS compliant GP dispensing module is still in development. They must also be aware that eligible patients must choose freely whether to use the EPS, which may direct their prescription to an EPS-enabled pharmacy, or to opt out, and exercise their choice to use their usual practice dispensary.

The DDA has produced a suite of resources to help protect eligible patients' right to a dispensary of their choice

The DDA is aware of dispensing patients who have inadvertently made an EPS nomination, which has resulted in the dispensing order sent to a pharmacy.

Eligible patients can be reminded of their right to choose to use their usual practice dispensary, and their right to ask a practice team member or a pharmacy to change or delete an existing nomination at any time, including at the point of prescribing.

Patients must receive sufficient information about the EPS and give their consent before a nomination is recorded. HSCIC advises that patients who are unhappy with their experience of nomination can complain to the pharmacy, dispensing appliance contractor (DAC) or GP practice. They can also complain to NHS England or their local NHS clinical commissioning group (CCG) if the complaint cannot be resolved locally.

Practices who suspect dispensing patients may be subject to aggressive EPS nomination marketing may also track local pharmacies' nomination statistics by visiting the nominations by dispenser monthly statistics held on the health and social care information centre website, and raise any concerns with the local NHS CCG or NHS England area team.

How can I support my dispensing patients' choices?

Tip 1: Reassure dispensing patients that they are not missing out if they do not use the EPS Thanks to integrated practice dispensing systems, dispensing patients already enjoy the benefits of electronic prescriptions.

Tip 2: Reassure patients they do not have to use the EPS. Dispensing patients can continue to benefit from using the practice dispensary without making any nomination. They can continue to use the practice dispensary even if they have nominated a pharmacy by indicating this choice to their prescriber.

Tip 3: Let patients know they are in charge! Explain to eligible patients that if they want to use their usual practice dispensary they can do so at any time – they just need to let the surgery know.

Tip 4: Ask patients using the EPS if they are happy with their nominations .
If eligible patients want to return to using the practice dispensary, advise them how to cancel their nomination.

DDA EPS resource pack

The DDA has published a resource pack for English practices in areas authorised to roll-out the Electronic Prescription Service.

The core aim of the pack is to ensure that dispensing patients are not inadvertently 'lost' to pharmacies operating the EPS.

The following resources are available for download:

- **Core EPS Information Pack**
- **Background information for English GP Practices**
- **A patient nomination SOP for practices, particularly pharmacy owners**
- **An EPS practice poster**
- **A template consent letter for dispensing patients (for local adaptation)**
- **A template consent letter for prescribing patients (for local adaptation)**

How good is your IT connection anyway?

Earlier this year practices were asked to rate their IT connection. This is what you told us:

- **43% said the quality of your connection was "generally inadequate and sometimes frustrating to the service/s I provide"**
- **2% described it as excellent**
- **Slow broadband speed and software issues were most commonly blamed for a poor quality connection**
- **You told us that you received mixed levels of support from your CCG IT team: 38% of respondents described the team as "not helpful" and 30% as "quite helpful".**
- **System suppliers were also "quite helpful", according to 46% of you.**

Thank you for all your responses. These will help the DDA, in collaboration with NHS England, to better understand practices' IT infrastructure and how this may impact on service development

DDA members can access the pack via DDA Online:

http://www.dispensingdoctor.org/resources/dispensary-management-zone/dda-members-resources/

Dispensing business training: Test your knowledge

Each DDA dispensing business training module is designed to help dispensing lead GPs and dispensary managers maximise the profitability of their dispensary. Available free and exclusively to DDA members, each module includes multiple choice questions to help staff identify any areas needing a quick recap. Questions and a certificate of completion relating to this module on: dispensary income: where the money comes from, can be found on the DDA Website at: **http://www.dispensingdoctor.org/resources/dispensary-management-zone/**

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The money practices receive for providing dispensing services is made up of two separate elements:

- remuneration (ie pay)
- reimbursement (for the cost of the drugs dispensed).

The remuneration element of dispensing practice pay is paid through a fee per item dispensed. This is known as the dispensing fee.

The fee is paid on a sliding scale based on the number of items dispensed. This is set out in documents published separately for England, Scotland and Wales, entitled: The Statement of Financial Entitlements.

The total sum (or envelope) available for doctor dispensing services in England is negotiated annually by the GPC and NHS England according to an agreed formula that takes account of costs and dispensing volume and the award, if any, made by the Review Body on Doctors' and Dentists' Remuneration (DDRB).

Once agreed, the envelope is fixed for the year. Thus, if the number of items dispensed rises or falls beyond that expected, the dispensing fee will have to be adjusted so that, overall, the agreed envelope is delivered. The calculation of the actual fee and the levels within the fee scale is carried out by an impartial technical steering group.

The dispensing fee claims are based on volumes of prescriptions dispensed per individual dispensing practitioner.

All GP principals, whether partners or not, count as individual GPs for the purpose of calculating the dispensing fee.

Most practices try to even out the number of items per doctor and there will be an option in the GP computer system settings to choose this facility.

The negotiated feescale is commonly replicated by the NHS in Wales for use by Welsh dispensing GPs.

Feescale effective from April 1, 2016

Total prescriptions calculated separately for each individual dispensing practitioner, in bands	Prices per prescription pence	in+/-p from outgoing feescale
Up to 455	214.9	3.4p (1.6%)
456 – 568	211.9	3.4p (1.6%)
569 – 683	209.1	3.3p (1.6%)
684 – 796	206.4	3.2p (1.6%)
797 – 911	204.0	3.3p (1.6%)
912 – 1023	201.8	3.2p (1.6%)
1024 – 1422	199.7	3.2p (1.6%)
1423 – 1990	197.8	3.1p (1.6%)
1991 – 2275	196.1	3.1p (1.6%)
2276 – 2844	194.5	3p (1.6%)
2845 – 3412	193.2	3.1p (1.6%)
3413 – 3981	192.1	3.1p (1.6%)
3982 – 4548	191.1	3.1p (1.6%)
4549 and over	190.3	3p (1.6%)

Scotland

There are some differences.

- A container allowance is paid as part of the dispensing fee
- The dispensing fee scale is not subject to the same envelope as is the case in England and there is less fluctuation in fee level
- The level of fee and the various payments are set out in the Scottish Drug Tariff - important if not essential reading for dispensing GPs in Scotland.

Understanding reimbursement

Reimbursement for the cost of drugs purchased for NHS dispensing purposes is based on the prices published in the Drug Tariff for England and Wales, and for Scotland. Basic prices for drugs (also referred to as net ingredient costs NIC) are published monthly, and are available in paper copy and also online.

Reimbursement should be considered a distinct income stream from remuneration.

Remuneration is paid to cover the operating costs of the dispensary: staffing, equipment, dispensary heating and lighting, etc.

Reimbursement is paid to cover the costs of purchasing drugs for dispensing against NHS prescriptions.

Key influences on reimbursement

Category M:
Category M of the Drug Tariff is the mechanism negotiated as part of the community pharmacy contractual framework to control purchase profits made by community pharmacies. Almost 600 common generic drugs are listed in Category M, the prices of which are usually adjusted on a quarterly basis.

Category M price adjustments affect dispensing doctors in England and Wales, and in Scotland, these are usually reflected in Part 7 of the Scottish drug tariff. Some price adjustments can be quite significant, and the published prices may not reflect actual buying prices.

Category M price adjustments are published during the month preceding the month from which they become effective, and stock holding for drugs joining, or currently in, Category M/part 7 should be carefully monitored during this time to avoid losses occurring due to reduced reimbursement prices.

Clawback:
Reimbursement for dispensing GPs is always subject to the discount abatement, a 'clawback' deduction that assumes a discount has been achieved on all purchases. The clawback rate is applied on a volume based scale, based on the £ value (total basic price/NIC) of all drugs dispensed by the (whole) practice in a given month. The current clawback scales can be found in the regional Statements of Financial Entitlements.

Clawback is applied even to items that do not attract any discount.
Common examples of 'zero discount' items include:

- Controlled drugs
- Fridge lines

Dispensing these items is automatically loss-making for the dispensary.

Declining discounts:
Declining availability of discounts available to dispensing practices has not been matched by an equivalent reduction in the clawback rate.

Maximising purchase efficiencies

Dispensing activity, in particular, the dispensing margin, should be regularly monitored, so that purchasing efficiencies can be maximised. For practices purchasing in the most efficient manner, margins of up to 35-40% are possible, and even small increases are worth pursuing.

Example to show impact on income of 10% rise in profit margin:
Monthly dispensary income = £40,000
Income @ 20% profit margin = £8,000
Income @ 30% profit margin = £12,000

To calculate your dispensing margin:

1. Calculate your Income = Reimbursement (basic price/NIC) minus clawback (plus any NHS PA allowance)
2. Work out your costs = Total monthly spend on drugs after discount and excl. VAT
3. The result is your margin = (Income minus costs) divided by income, and multiplied by 100

The practice's monthly NHS reimbursement statement should be regularly scrutinised as part of monthly reconciliation to reduce discrepancies between submission and payment.

Prescribing and dispensing activity information

Online practice level prescribing information can be useful to identify item-level prescribing and, hence, dispensing activity. This is an important first step to maximise purchasing efficiency.
Further advice on maximising purchasing efficiencies will be given in a subsequent module of this course.
Prescribing data is available in varied formats for different areas of the UK:

England: NHS business services authority portal:
http://www.nhsbsa.nhs.uk/3607.aspx

Scotland: NHS Scotland Information Services Division:
http://www.isdscotland.org/index.asp

Wales: NHS Wales Shared Services Partnership:
http://www.primarycareservices.wales.nhs.uk/data-publications-1

Statements of Financial Entitlements for England, Scotland and Wales can be found on the DDA website.

Operating margin

The 2010 Dispensing Practice Cost of Service Inquiry recognises that after all costs are considered an 'average' dispensing practice was operating on a 7% margin.

Since 2010, discounts have declined, and drug and other running costs (staffing, utilities, etc) have gone up - all of which will impact on operating margin in 2016 and beyond.

Other influences on operating margin will include a practice's prescribing mix - in particular its use of automatically loss-making drugs that attract no discount, yet are still subject to the discount clawback - as well as higher margin generics.

Private prescriptions

A small amount of income can be earned from private prescriptions for a group of drugs that are defined by the GP contracts. This group includes medications for malaria prophylaxis and blacklisted drugs, as listed in the Drug Tariffs.
There are two charging options:

- Charge a prescription fee and do not dispense the item (patient takes the item to a pharmacy)
- Do not charge a prescription fee, but dispense the item from your dispensary and charge a dispensing fee plus a mark-up on the basic price of the drug.

Fees and mark up are decided at individual practice level. Charges should account for costs of the labour and packaging involved in the dispensing process, and may reflect private dispensing charges levied by local pharmacies.

If you dispense a private prescription you must add VAT. Pharmacies do not charge VAT on private prescriptions.

The DSQS

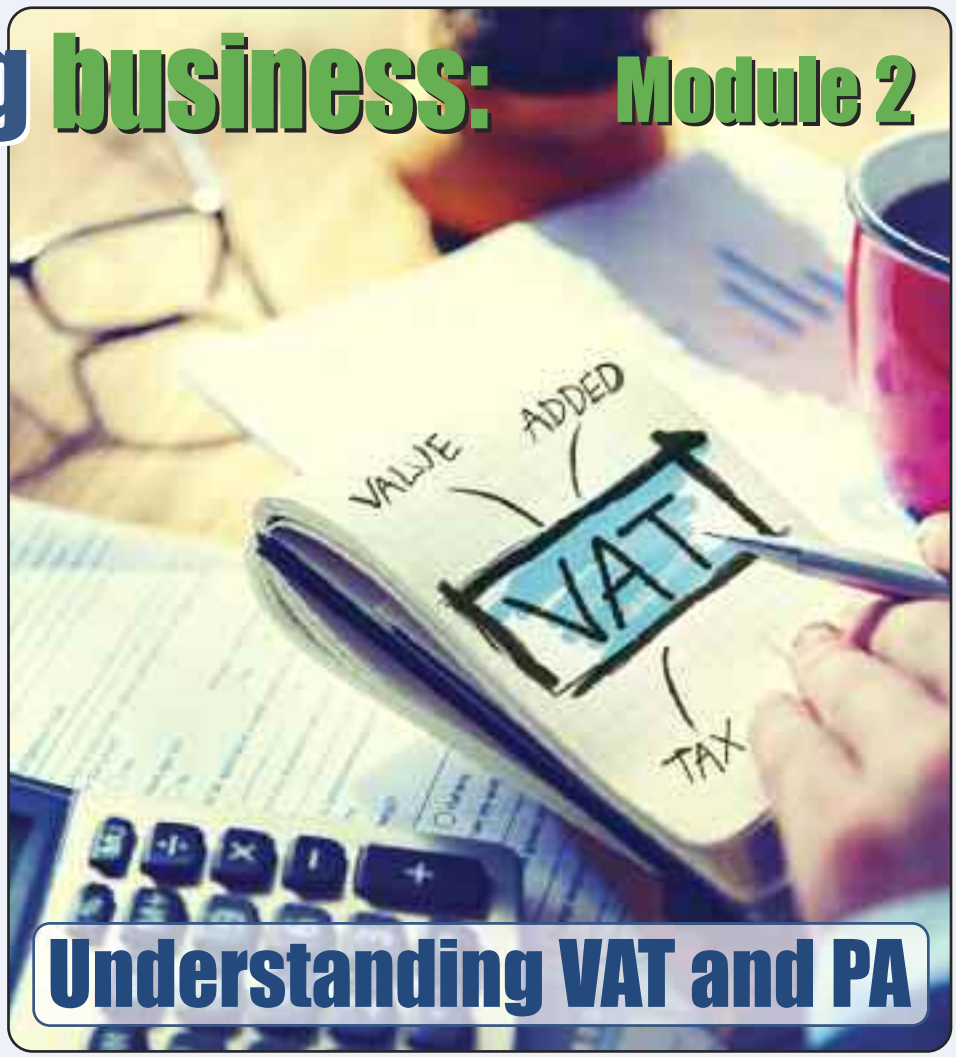
The Dispensary Services Quality Scheme (DSQS) is a voluntary scheme designed to reward quality in dispensing practice in England and Wales.

Under the terms of the scheme, in return for compliance with a number of criteria, an annual payment of £2.58 per dispensing payment is payable to the practice.

The terms of the DSQS will be discussed in a later module on quality in dispensing practice.

Dispensing business Modules: Test your knowledge
Questions and a certificate of completion relating to this module on: PA and VAT can be found on the DDA Website at:
http://www.dispensingdoctor.org/resources/dispensary-management-zone/

Dispensing business: Module 2



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Understanding VAT and PA

Personally administered items

All dispensing practices are entitled to claim the NHS PA allowance for items listed by the NHS as 'personally administered'.
In general, PA claims for the following items will receive the NHS PA allowance:

- Vaccines, anaesthetics and products containing local anaesthetic, and all injectable products
- Diagnostic reagents
- Intrauterine contraceptive devices (including drug-releasing IUCDs, contraceptive caps and diaphragms, but NOT contraceptive implants)
- Pessaries which are appliances
- Sutures (including skin closing strips) listed in the Drug Tariffs (England & Wales: Part IXA; Scotland: Part 2)
- All skin adhesives listed in the above sections of the Drug Tariffs.

Note: Items centrally supplied as part of specific immunisation programmes (eg, the childhood influenza and the shingles immunisation programmes) are not considered PA items by the NHS for payment purposes.

Real time information on the items that currently attract the NHS PA allowance can be found in The Dictionary of Medicines and Devices (dm+d), annotated as 'Personally Administered Indicator – Attracts an administration fee'.
Visit the dm+d:
http://www.nhsbsa.nhs.uk/1121.aspx

What you are paid

The NHS Personal Administration allowance, paid automatically following your monthly NHS submission claim, is calculated by applying VAT to the reimbursement price of the drug after clawback, and adding a dispensing fee.
Thus: (Basic price/NIC of drug minus clawback rate) multiplied by VAT rate + relevant dispensing fee/s)

Practices are advised to take a close look at their payment statement to assess the accuracy of the PA payment made.

Input tax

Some items considered PA by the NHS, ie 'on the NHS PA list', are also items that HMRC considers to be dispensed items, ie items that can be routinely dispensed and taken home by the patient for self-administration.

There is no definitive list of such items, but examples include:

- Insulin
- Metoject
- sumatriptan injection
- Genotropin
- Clexane
- Innohep
- Instillagel
- throat sprays containing local anaesthetic.

These items can attract both the NHS PA allowance, and the input tax repayment (reclaimed VAT) from HMRC.

PA problems

1. Not every item that is personally administered is classified as such by the NHS. An example is Implanon. Because Implanon cannot be dispensed, VAT on these purchases cannot be reclaimed, either. This leads to the undesirable situation where the practice cannot reclaim the VAT element of the purchase from either source.

2. Most PA items attract no discount, which means that once VAT is applied to the purchase price, the PA allowance may not fully cover the purchase costs and a dispensing loss occurs.

   The contract does permit dispensing practices, with the consent of the patient, to issue a prescription for dispensing at a pharmacy rather than supplying themselves, but this is generally an unsatisfactory situation.

3. Some VAT inspectors are unaware of the rights of the practice to reclaim both the input tax and the NHS PA allowance on eligible products. In this scenario, seek advice from your accountant

Practices should ensure that they reclaim input tax on all items that can be dispensed, as well as check payment for the PA allowance for eligible products.

VAT classifications

A typical dispensing practice will have a variety of VAT classifications to consider when accounting for VAT. Here are the most common items you will encounter:

Zero-rated items are:

- a qualifying item dispensed to the patient on the basis of an NHS prescription and taken away from the surgery, and supplied by a doctor for the personal use of the patient
- prescription charges for NHS items dispensed
- 'qualifying goods', which are defined as any goods designed or adapted for use with any medical or surgical treatment except for hearing aids, dentures, spectacles and contact lenses.

Exempt supplies are

- NHS payments received in respect of the drugs or appliances that you have personally administered, injected or applied to a patient in the course of medical treatment
- prescription fees for writing a private script which is not dispensed
- health services provided under GMS, PMS, APMS
- locum reimbursement
- recompensing a practice for time a doctor is not in surgery at a meeting
- reports and certificates aimed at the protection, maintenance or restoration of health of the person concerned
- reports and certificates supplied solely to provide a third party with a necessary element for a decision for insurance purposes
- private vaccination fees

Standard rated supplies are:

- appraisal service
- private dispensing: If you dispense a private prescription you must add VAT. Pharmacies do not charge VAT on private prescriptions they dispense
- reports and certificates supplied solely to provide a third party with a necessary element for taking a decision for legal purposes.

Apportionment

Part of your business is exempt for VAT (medical) and part is not (dispensing). HMRC allows you to calculate the input tax (VAT recoverable) on the dispensed part by using the simple three-step calculation:

1. Add total dispensing income to total standard-rated supply income, eg, DVLA reports supplied.
2. Divide total by gross practice income.
3. Round up the resultant percentage to the next whole number and apply to VAT paid on all practice non-attributable 'overheads'.

Anything that increases dispensary income will increase the proportion of input tax (VAT) you can recover.

Consumables

Some consumables will be used by the dispensary and some in the rest of the surgery. Dressings are one example.

To calculate the input tax due on consumables used by the dispensed part of your business, use your apportionment ratio.

De minimis

The de-minimis rules require a business to pass two tests before it can be treated as fully taxable and entitled to reclaim all exempt input tax in any tax year.

Few dispensing practices, if any, will pass even the first test, since this requires a net value for PA purchases and the exempt proportion of overhead expenses to be less than £3,125 per month (£3,125 x 20% = £625).

The VAT paid on purchases of dressings should be subject to apportionment

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Rurality presents the greatest recruitment challenge, Scottish parliament told

Rurality has been flagged as the main challenge facing GP recruiters in Scotland, a major survey has concluded as two rural health boards report the highest number of vacancies in Scotland. In Scotland's primary care workforce survey 2015, almost one in five respondents highlight difficulties recruiting to rural areas, and acknowledge the higher demands placed on the GP workforce in rural areas.

In rural areas, almost double the number of GPs and weekly GP sessions per capita are needed compared to the Scottish average. While in Scotland as a whole there are an estimated eight GPs per 10,000 registered patients, NHS Orkney reports 14 GPs for the same population. Due to disperse populations, four other rural boards - NHS Highland, Borders, Shetland and Western Isles - also report a GP per capita demand above the Scotland average.

Population "geographical spread" also requires Orkney GPs to deliver 112 sessions per week, compared to the Scotland average of 59 weekly GP sessions for every 10,000 patients. And while NHS Highland, Shetland and Western Isles also report a demand for weekly sessions well above the Scotland average, two boards - Western Isles and Shetland - report Scotland's highest vacancy rates (16.5% and 17.9%). This compares to vacancy rates between 2.5-3.4% in the more urban board areas.

The report notes: "With the exception of NHS Shetland, all NHS Boards reported having to take actions due to being unable to fill all shifts as planned, with nine NHS Boards reporting having to do so at least weekly. The most common action taken due to unfilled shifts was for staff to work longer shifts or start a shift earlier."

Other key findings include:

- One in five (22%) responding GP practices report current GP vacancies, and one in ten report vacancies lasting over six months
- Over a third of GPs working in Scottish general practice are aged 50 years old or over.

DDA political lobby documents highlight the unique nature of rural medical services

Responding to the report, health secretary Shona Robison announced a £2 million fund to support GP recruitment and retention.

Dispensing GP practices in Ayrshire & Arran, Dumfries & Galloway, Highland, Shetland, Western Isles, Orkney, Grampian health boards are to benefit from a common recruitment strategy across the boards, and a new community of rural GPs, organisations and health boards to boost support and networking.

Small Welsh dispensing practices are getting "stuffed"

Recruitment woes stir up the perfect rural storm

Wales' smallest, all-dispensing practices are "getting stuffed" by the combination of the higher cost of service provision, diseconomies of scale, unfair reimbursement policies and the struggle to recruit GPs to rural areas, GPC Wales deputy chairman Dr David Bailey has warned.

And, while proposed changes to the control of entry regulations would help protect well-run dispensing practices from predatory pharmacy applications, they won't remove the underlying problems facing smaller practices, Dr Bailey has warned. He said: "The dice are loaded in favour of larger practices."

His comments come as analysis of 2013-15 GP workforce figures in Wales reveals a 7 per cent fall in the number of Welsh dispensing practices, a 15% drop in the number of dispensing GPs and a 20 per cent crash in the number of dispensing patients between 2013-15.

They also follow a Freedom of Information Act request made by DDA Online, which reveals that at the end of January, 2016, dispensing practices accounted for almost two in five of the applications for rescue funding made by GPs in Wales – despite dispensing practices accounting for fewer than one in five of all GP surgeries across the nation. "The figures are not surprising," Dr Bailey told DDA Online, adding: "and I don't believe the trend has bottomed out yet."

Dispensing volumes in Wales rose 1.2 per cent during 2014-15 to 79.5 million items, and of all the UK nations, Wales dispenses the highest number of prescription items per head of population – at 25.7, new figures show.

But, he said, discussions on improving reimbursement are like "swimming through frozen treacle".

Dr Bailey told DDA Online that the BMA would as a priority be seeking dialogue with the new health minister Vaughan Gething to discuss ways to incentivise GP recruitment to rural Wales. "Practices are handing back to Board control, simply because there are too few GPs."

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