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A welcome from the DDA Chief Executive Matthew Isom

Welcome to the latest of our educational supplements brought to you in association with Actavis.

The DDA held its annual conference at the Best Practice Show on 19-20 October at the Birmingham NEC. Thanks to all of you that took time out of your busy schedules to attend. It was our most successful yet and my colleagues and I really enjoyed meeting our members. If you haven't yet attended one of our conferences, please consider doing so next year. The dates will be Wednesday 18 and Thursday 19 October 2017.

During our conference, the details of the Community Pharmacy Contract changes were published. Though community pharmacies are funded by a totally separate budget – and so, changes to their remuneration do not affect dispensing practices - this does not mean that dispensing doctors have any reason to be complacent. We will have to ensure that the dispensary service competes with the new service led pharmacy model, or we may find that our patients vote with their feet.

It is important to emphasise that we are living in the harsh world of austerity – the NHS faces a number of years of hard slog until at least 2020 and GPs will not be completely immune from this reality. Reimbursement, affecting dispensing practice, may weather its fair share of that.

As ever, the DDA will fight your corner ferociously!

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DISPENSING DOCTORS' ASSOCIATION
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November 2016: Issue Three

DDA 2016 annual conference successfully 'Deals with Demand'

The DDA 2016 annual conference has been hailed a great success. DDA Board member Dr Philip Koopowitz said the conference had once again "provided an excellent networking opportunity for dispensing practices from all corners of England and Wales", and that it "had delivered a stimulating conference programme designed to deliver excellence in dispensing practice".

Prab Uppal, GP, Albrighton Medical Practice added: "As a GP looking at the dispensing side of the practice, this has really helped to give me a better understanding. There's lots of good medical information available here. The quality of the event is very good."

Over the two days of the conference, 150 dispensing GPs, nurses and dispensary and administration staff were able to spend time on the DDA conference stand, networking with Board members and fellow DDA members, to discuss solutions to the many challenges facing dispensing practices today. Conference delegates were the first to hear the announcement of the pharmacy funding cuts, and were immediately able to call on the expertise of pharmacy-owning dispensing GPs to discuss the implications for their practices.

Popular presentations at the 2016 DDA annual conference included dispensary profitability practice and theory, and CQC inspections of dispensing practice, which between them attracted over 300 attendances.

We hope to see you there!

Best Practice
18-19 October 2017
Birmingham NEC

Compete or watch pharmacies eat away at your income, DDA chairman warns...

Dispensing practices will have to think about how they are going to adjust to the new pharmacy funding environment, Dr West told the 2016 DDA annual conference in his annual chairman's address.

In light of cuts to pharmacy funding taking effect from December 2016, the DDA chairman said: "Pharmacies will start to look at delivering clinical services as a way to bring the money back in. Dispensing practices can either compete or accept that pharmacies will eat away at your service income."

He also warned that changes to reimbursement presented "a real risk" for dispensing practices.

In his presentation, Dr West looked at the 7.4 per cent increase in GP dispensing fees and said that this should not be considered a pay rise. The increase relates solely to a previous under-delivery of the agreed dispensing fee remuneration 'envelope' and takes no account of cost of living rises, "so there is an efficiency saving year on year for the NHS", he said.

In his presentation, Dr West introduced the topics to be discussed by speakers during the 2016 annual conference, including CQC inspections, new models of care, pressures on purchase margins and the European Falsified Medicines Directive.

More information on the pharmacy funding cuts – and their implications for dispensing GP practices - can be found on **page 3** of this newsletter, and on the conference topics on **page 8.**

Quarter three 2016 Tariff adjustments

Category M reimbursement prices for the third quarter of 2015- 16 came into effect in October. The following are the summary points

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

- The current quarter sees a new Category M tariff with a negative reimbursement adjustment of 1.3 per cent
- Compared to quarter two, there is a 1.9 per cent increase across the 'core range', which include products included in Category M since its inception
- Approximately £6 million per quarter is being removed from Category M
- From October, three products have been deleted from Category M (alfacalcidol 1mcg x30 caps, 250ng x 30caps and 500ng x30 caps)
- From October, three products have been added: benzydamine 0.15 per cent oromucosal spray sugar free x30ml, frovatriptan 2.5mg x 6 tabs and rasagiline 1mg x 28 tabs
- There are now 599 products in Category M, of which 41 have stayed at the same reimbursement level as June 2016. There have been a total of 291 reimbursement increases and 267 decreases in this quarter
- 290 items are up in price – 16 by more than £1
- 39 remain unchanged from the July Category M
- 263 down in price – 36 by more than £1.

July – October Category M analysis

Four products have more than doubled in price	Pack size	July £	Oct £	£ +/-	% +/-
Isosorbide mononitrate 10mg tablets	56	1.50	6.97	5.47	365%
Isosorbide mononitrate 40mg tablets	56	1.72	6.01	4.29	249%
Isosorbide mononitrate 20mg tablets	56	1.19	3.28	2.09	176%
Flecainide 50mg tablets	60	3.39	6.82	3.43	101%
Two items have seen the reimbursement price fall by at least 40%					
Duloxetine 30mg gastro-resistant capsules	28	4.81	2.9	-1.91	-40%
Candesartan 2mg tablets	28	2.16	1.03	-1.13	-52%

Wavedata price trend analysis

October 2016 analysis reveals one price PI market

ONLINE EXCLUSIVE!

Market analysis for the past four months suggests that PI suppliers are simplifying price offers and are beginning to treat pharmacists and dispensing GPs as equals: this may be because dispensing GPs are beginning to accept PIs as a routine part of the dispensary portfolio.

As a whole, GPs continue to negotiate better prices for generics despite market price fluctuations. Headline price risers and fallers for October include among the risers four packs of fentanyl transdermal patches, and two each of mirtazapine, spironolactone and telmisartan tabs, and among the fallers three packs of isosorbide mononitrate tabs and two packs of amiodarone tabs.

Fallers

The average price of isosorbide mononitrate tabs 10mg x56 fell dramatically in October as prices above £5.00 disappeared from the dispensing doctor market and were replaced by new offers of less than £2.00. This was despite an increase in the drug tariff from £1.50 to £6.97. Excellent prices below £2.00 were available to dispensing doctors from Beta and OTC Direct, and to pharmacists from Beta, Actavis and Medihealth North.

The 40mg x56 pack of isosorbide mononitrate tabs saw a similar increase in drug tariff (£1.72 to £6.01) accompanied by another large fall in the average price. The best market offers were below £2.00.

Amiodarone tabs 200mg x28 also saw an increase in drug tariff in October (from £1.75 to £2.00) as well as a fall in the average price. A number of companies reduced their prices in October, and the best offers were below £1.50.

Risers

October saw market prices for naratriptan tabs 2.5mg x12 edging up toward £50 when they were closer to £3.00 six months ago. The few remaining prices below £30.00 were being offered by Numark, Lexon and Phoenix. This price hike was accompanied by an increase in the Scottish drug tariff of naratriptan tabs 2.5mg x6 from £1.90 in April to £24.55 in October. The English and Northern Irish drug tariffs rose a tiny bit to £2.03 in October, but were considerably out of step with the market.

The price changes for aspirin tabs 300mg x32 were a mixed bag in October, with reduced prices from Alliance but on the whole, many low priced offers disappeared. In September there were 12 offers below £1.00, but this fell to six in October.

In October the average price market of mirtazapine tabs 15mg x28 rose as a number of suppliers increased their prices. In September there were no prices above £2.00, but in October there were 22 from five different companies. The best offers were below £1.00.

Brought to you exclusively by the Dispensing Doctors' Association

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

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What the pharmacy funding cuts mean to dispensing practices

The much-criticised pharmacy funding cuts come into effect from December 2016. Here's what all dispensing practices need to know to protect their dispensing lists

On Thursday 20 October 2016 the Government imposed a two-year funding package on community pharmacies in England (only), comprising a £113 million reduction in funding in 2016-17 – a reduction of 4 per cent on 2015-16 – to be followed by a reduction of £95m in 2017-18. By the end of 2018 the average pharmacy contractor will see their individual NHS pharmacy funding reduce by an average of approximately £17,800.

As well as introducing swingeing efficiency savings for the sector, the new funding package implements a number of changes to the current remuneration system, effectively moving community pharmacy away from a volume-based model to a model based on the delivery of high quality clinical services.

The details of the remuneration changes are provided in the box below.

Dispensing practices, whose professional fees are delivered through a separate funding mechanism, are fortunately unaffected by these changes. However, there are three main aspects of the pharmacy funding package for 2017-18 that should concern dispensing practices and their patients.

1 The Pharmacy Access Scheme (PhAS)

Dispensing practices with dispensing list sizes that are vulnerable to a pharmacy application will consider that the terms of the PhAS offer a degree of protection for their dispensing list – although it should be stressed that the PhAS will not remove the threat of a pharmacy application entirely.

Conversely, dispensing practices may see a dispensing list opportunity in planned amendments to the 2013 control of entry regulations expected to come into force in December 2016. These prevent a new pharmacy stepping in straight away if a pharmacy closes or merges with another – where this does not create a gap in provision.

For those GPs already operating a pharmacy, there is the future viability of that business to consider, the commercial strength of existing local competitors, and the PhAS eligibility criterion that excludes new entrants.

2 Pharmacy service quality

The Department of Health has set out a clear expectation of an improved range and quality of pharmacy clinical services.
Dispensing practices which may be affected by aggressive pharmacy service marketing are urged to take note of the direction of travel for pharmacy services, and ensure their service offering continues to compete effectively.

3 Reimbursement

Although the pharmacy funding changes relate to remuneration (pay) rather than reimbursement, changes to reimbursement have already been mooted and the indications are that the current agreement relating to retained purchase margin, and aspects of the drug tariff will change.

These proposals will all affect dispensing practices.

Pharmacy only: Changes to current fees

1 New: A Single Activity Fee (SAF)

For December 2016 to March 2017 the SAF is set to £1.13 per item. The SAF is then expected to rise in 2017/18 to a level of £1.24 per item.

From December 2016, the SAF replaces the following professional fees and payments:

- Pharmacy dispensing fee: 90p per item
- Practice Payments (value dependent on dispensing volume)
- Repeat Dispensing Fee: £125 per month
- EPS Monthly Allowances: £200 per month.

2. Establishment payment

Establishment payments are being reduced from Dec 2016 by 20 per cent compared to 2015/16 levels, and will be phased out by April 2020. Establishment payments are linked to monthly dispensing volumes, and from December 2016 will range from £0 -£1,673 per month.

Indicative values and an income calculator are available from PSNC via this link: **http://bit.ly/2fSL8Vi**

2 The Pharmacy Access Scheme (PhAS)

Pharmacies that are eligible to join the PhAS will receive funding based on payments received during 2015-16. The average PhAS monthly payment is £2,900 in 2016/17 and £1,500 in 2017/18. PhAS payments continue monthly until the payment for March 2018.

PhAS eligibility criteria include:

- The pharmacy is more than a mile away from its nearest pharmacy (measured by road distance)
- The pharmacy is on the pharmaceutical list as at 1 September 2016
- The pharmacy is not in the top 25 per cent largest pharmacies by dispensing volume (ie, dispenses up to 109,012 prescriptions a year – or around 9, 084 per month).

The full list of eligible PhAS pharmacies is available from DDA Online via this link: **http://bit.ly/2ffv5yP**

3 Quality Payment Scheme (QPS)

To qualify for the QPS, pharmacies will need to meet four criteria:

- Provision of at least one specified advanced service, eg, contraception and flu jabs
- NHS Choices entry up to date
- Ability of staff to send and receive NHS emails
- Ongoing use of the Electronic Prescription Service.

QPS payments are made using a points-based system, capped at 100 points a year, with each point valued at £64. Points are awarded for fulfilling criteria in eight domains.

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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 purchasing efficiency, can be found on the DDA Website at: **http://www.dispensingdoctor.org/resources/dispensary-management-zone/**

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The very first step in maximising the performance of your dispensary is to give this most important of assets the attention and resources it deserves.

In the rural practice the dispensary fulfils two very important functions:

- It provides patients with access to medicines where otherwise there may be none
- It provides an important cross subsidy to the wider practice, which may otherwise face declining income (reducing rural subsidies/contract payments etc) and the increased costs of service provision because of the remote local geography.

These important points are now acknowledged by politicians as the reality of modern rural general practice and it should be readily acknowledged by the rest of the practice as well.

One of the most important concepts to grasp is this:

The dispensary will not look after itself

Getting your buying right is fundamental to profitability – increasingly so as reimbursement and remuneration remain under pressure – and this needs proper understanding, and investment by the practice principals.

Based on average dispensing practice NIC (England) a 5 per cent increase in net profitability equates to extra income of around £2,600 per month – income that can be used to fund a dedicated dispensary or purchasing manager role. Experts say that with care and attention of a lead dispensing GP and a dispensary manager, net dispensary profit margins of between 25-35 per cent - even 40 per cent - are possible. On this basis, the investment in these two roles easily pays for itself.

Know your numbers

The next important step is to understand the current picture of practice prescribing – ie, the 'where we are now' situation.

Practices in England have a wide range of prescribing datasets available at the NHS BSA Information Services Portal. Useful reports that can be used to benchmark baseline prescribing and at regular intervals thereafter to continue the process of improving profitability include:

- Practice Detailed Prescribing Information (PDPI)
- Personally Administered Items
- Twenty Leading Cost Drugs report (practice prescribing ranked by total NIC)
- Potential generic savings (brands that have generic alternatives).

Prescribing information portals are also available regionally, offering varying amounts of information:

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
via the link: http://bit.ly/2elVX14

Without too much difficulty, the dispensary should be able to use these reports to quantify the practice's overall and drug-level prescribing.

This can then be used to try and gain leverage with suppliers: areas of high volume purchase can be used in a negotiation with suppliers to unlock greater discount rates. In addition, practices can 'compare the market' and should not be afraid to ask a preferred supplier to price match a competitor supplier's discount.

Chasing discounts

Although the number and size of discounts available to dispensing practices are decreasing, there are still discounts to be had.

If a drug is supplied via one or more wholesalers using a traditional or reduced wholesaler distribution model, a wholesaler's discount may be available (average: 6 per cent). In addition, for some branded products, particularly those with competition, a 'manufacturer's discount' will be additionally offered.

Wholesaler and manufacturer discounts are individual to each wholesaler, but when combined, discounts of 40-50 per cent of the basic price may be available. Thus, it is well worth spending the time to shop around to find/negotiate the best terms for your practice.

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Please see below for an illustration of the impact of discount on profitability.

Vipdomet tabs x 56 (NIC = £26.60)			
	Discount: 0%	Wholesaler discount: 10%	Wholesaler and MDS discount: 40%
Purchase price (with discount applied)	£26.60	£23.94	£15.96
Clawback (NICx11.18%):	£2.97	£2.97	£2.97
Reimbursement	£23.63	£23.63	£23.63
Profit (Loss)	(£2.97)	(£0.31)	£10.63

Updated information on wholesaler and manufacturer discounts can also be found on the DDA website's RWM/DTP page

Shopping around for generics on cost alone can be fruitful

Other sources of discount

Further additional discounts – as well as additional member services and resources - can be accessed by joining a buying group such as Forte, PSUK or St Thomas Group. A membership fee will apply, so practices should ensure that the benefits are not offset by the membership fee and any subsequent limitations on your willingness/ability to shop around.

Ordering direct from companies such as Clarity or Williams Medical can also result in additional discounts on specific lines.

Some wholesalers will offer a very limited range of medicines – and sometimes with short shelf lives - but at much larger discounts.

Discounts should be weighed up against problems relating to continuity of supply, waste, time spent sourcing products and other charges (carriage).

Examples of shortliners include:
Forte Direct, Lexon and OTC Direct.

Parallel imports

Parallel imports (PIs), or products that have been imported to the UK from another European market and repacked for the UK market, may present an opportunity to access otherwise unobtainable purchase price discounts. Recent market data analysis also suggests that use of PIs is becoming more prevalent among dispensing practices.

Although legal, and subject to regulatory control, the supply of PIs can confuse patients and may contribute to adherence problems.

There are also wider implications for UK product development and pharma industry marketing strategies.

Generics

Generics will make up the majority of your purchases by volume, but, typically, only around 25 per cent of your total wholesaler's bill. Most generics can be bought at a discount per cent of the basic price, and shopping around on generics on cost alone can be fruitful.

But, constant changes in supplier, and hence, the product's presentation, can be confusing for patients, and is a risk factor for dispensing errors.

Some generics' suppliers run loyalty schemes that offer volume-related rebates on their products. Examples include the **Actavis Accumulator scheme**.

Charges

When shopping around for discounts, practices should consider whether wholesaler surcharges will apply - for low volume orders and product ordered in error, as well as fuel costs. It should be remembered that claiming out of pocket expenses (OOP) is only allowed in very limited circumstances.

For more information on claiming OOP see:

Part II, Clause 12 (Drug Tariff for England and Wales) and, in Scotland, PSD's information for dispensing practices

Purchasing and stock holding should always be considered in light of adjustments to the reimbursement prices of products listed in Part VIII of the Drug Tariff for England and Wales and in Part 7 of the Scottish Tariff.

Amendments to the Drug Tariffs are published monthly, and at least one week in advance of the new prices coming into effect.

Practices should be particularly aware of price changes implemented in response to market shortages (called concession prices in England and Wales, and adjusted prices in Scotland) and the (usually) quarterly adjustments to Part VIII Category M in January, April, July and October. Deletions from Category C (and their equivalents in Scotland) are also important to keep abreast of, as the impact on reimbursement prices of these changes can be significant.

Ordering direct from companies can also result in additional discounts on specific lines

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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 medicines optimisation in the DEM library, located on the DDA Website at: **www.dispensingdoctor.org/resources/clinical-zone/dispenser-education-modules/**

Dispenser Education Module 4

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In recent years, medicines optimisation has become a hot topic in NHS circles. While the term may be relatively new, the principle is not: helping patients get the most out of the medicines they take. By the end of this article, you will:

- Know what medicines optimisation is and why it is important
- Have an idea of how the MO agenda can be incorporated into everyday working life.

What is medicines optimisation?

Medicines optimisation is described as: "a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines. Medicines optimisation applies to people who may or may not take their medicines effectively. Shared decision-making is an essential part of evidence-based medicine, seeking to use the best available evidence to guide decisions about the case of the individual patient, taking into account their needs, preferences and values."

It may be wordy, but this is the definition accepted by the NHS. This definition is also included in guidelines published by the National Institute for Health and Care Excellence (Nice) last year, called: "Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes."

Why is medicines optimisation important?

People are living longer in the UK, but many are not in the best of health in their old age. A 2012 Department of Health report suggested that 15 million in England have a long-term condition (an illness that is not curable but can be controlled using medication or other therapies) and the chance of this increases with age: the document stated that 58 per cent of people aged over 60 years said they had at least one chronic condition compared to 14 per cent of under 40 year olds.

There are also many people who suffer from more than one long-term condition (LTC) at the same time – diabetes plus hypertension, for example – with the DH report stating that a quarter of people aged over 60 years fell into this category. The ageing population of the UK means the proportion of the population with multimorbidity, as it is sometimes called, is also set to rise: around 1.9 million people in 2008 were said to have more than one LTC but by 2018 it is anticipated that approximately 2.9m people will be affected.

With medicines the most common intervention in healthcare, the increase in multimorbidity has been accompanied by growing prescription numbers. In 2003, the average number of prescription items per year for any one person in England was 13, but by 2013, it had grown to 19.

Polypharmacy, the term used when someone is on multiple medicines, is therefore an ever more pressing consideration for clinicians when trying to decide how to best manage their patients. In some cases it can be beneficial to be on more than one medicine at a time (someone with type 2 diabetes, for example, may need more than one hypoglycaemic agent to bring their blood sugar under control), but in others, it can be more problematic because of interactions or accumulated side effects.

This is where medicines optimisation (MO) comes in. All too often, a patient with multimorbidities is under a number of specialist clinicians – an individual who has had type 2 diabetes for a number of years, for example, is likely to be under an endocrinologist plus a cardiologist for high blood pressure and heart checks, an ophthalmologist to make sure that any complications affecting the eyes are being addressed, and a renal consultant to keep

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tabs on kidney function – and there can be a tendency for each condition or complication to be treated in isolation. MO brings everything together, taking a holistic look at the patient and all their conditions and medicines and how they are affecting each other. It also makes sure that the person who is an expert on that individual – the patient themselves – is at the heart of any decisions that are made.

Putting MO into practice

The overarching aim of MO is simple enough, but it can be difficult to know where to start. To make it easier, it can be broken it down into three core principles:

- Try and understand the patient's experience
- Choose medicines based on evidence
- Make medicines use as safe as possible.

The Nice guidelines on MO recommend a number of actions that healthcare professionals can take to help patients get the most out of their medicines.

In dispensing practices, some of the most relevant include the following:

1. Make sure you have an up to date list of all the medicines your patients are taking, particularly for those who have just been discharged from hospital or are moving from one healthcare setting to another. This is called medicines reconciliation.

2. When a patient transfers from one care setting to another, make sure all your information about them is still current and ideally includes the following:

   - The patient's contact details
   - Contact details of the GP practice and anyone else involved in the patient's care, for example, carers
   - Information about allergies and past problems with medicines
   - Current medication including dose, formulation and indication
   - Changes to medicines, for example, items that have been stopped or added, or dosage changes, and the reason
   - Date and time of last dose of anything taken infrequently, eg. a weekly or monthly medicine
   - Information provided to the patient
   - Anything else relevant, such as any adherence issues and how they are being addressed, and when a medication review is due.

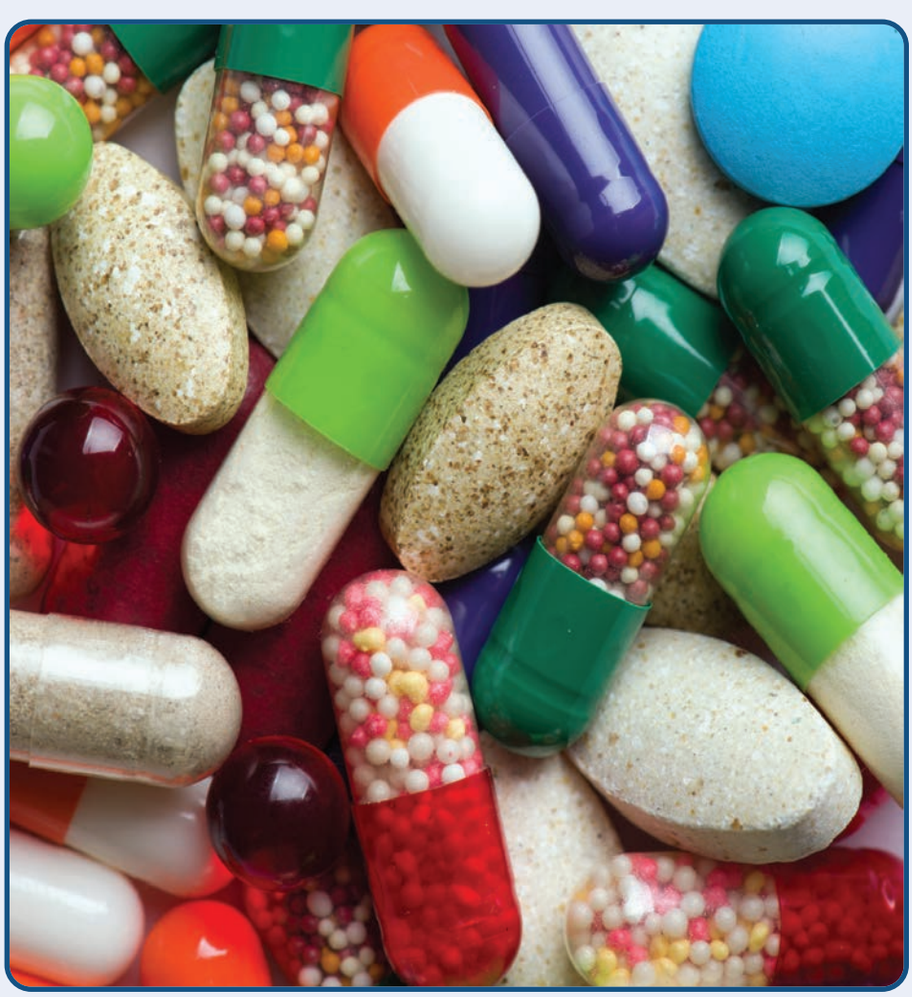
3. Review someone's medication with them if you consider there to be a need. This might be because they seem to be getting confused about which medicine they are taking for each condition or because they are having problems remembering different dosing regimens for different drugs, for instance. This doesn't have to be very detailed or time-consuming – and in fact making the review either of these things is likely bewilder further rather than adding any clarity – but simply sitting down and running through each item, what it is for and how it is taken gives the patient an opportunity to raise any issues they are experiencing.

   For some patients, particularly those on several medicines or with a long-term condition, a self-management plan can make a real difference. As well as including information about medication regimens, this plan may also feature details such as when to contact a health professional for advice and instructions on using drugs safely, as well as how often the plan is to be reviewed.

4. Learn from mistakes, both those made by staff in your dispensary and those made by patients. While your dispensary will have processes in place to minimise the chance of errors occurring, unfortunately sometimes they can still happen but it is important to try and work out the reason for the incident so the chance of a recurrence can be reduced. Similarly, if a patient has not taken their medication properly, talk to them about why this is and see if there is something you can do to improve adherence.

5. One of the most significant actions you can take to promote MO is to keep lines of communication open with your patients. Rather than handing out dispensed items without a word, a simple question such as "Do you know what you are doing with this?" or "You have been on these for a while, how are you getting on?" gives an opportunity for patients to raise an issue that has been niggling them or ask a question in return.

For best effect, a medicines review should be as simple as possible



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The following are a selection of reports from the 2016 DDA 2016 annual conference held at the NEC Birmingham on October 19-20.

Best Practice
19-20 October 2016
Birmingham NEC

Safety ratings cause practices the most inspection problems

Safety is the domain that troubles most practices, including dispensing practices, CQC head of medicines management Sarah Billington told the DDA 2016 annual conference.

To date, around two-thirds of dispensing practices have been inspected by the CQC, and average performance is better than for non-dispensing GPs. Recently, two Devon DDA members have received outstanding ratings, one on all five measures.

In dispensing practices rated as requiring improvement or inadequate, requirement notices and enforcement have covered issues such as:

- Unsafe storage of medicines
- Insecure storage of blank prescription forms
- Lack of systems to ensure safe disposal of patient prescribed medicines
- Inadequate processes for managing medicine alerts
- Insufficient training for dispensary staff
- Inadequate systems for assessing risk of supplying medicines to/from external locations
- Health and safety of the general dispensary environment
- Failure to follow procedures in line with current guidance and legislation on storage, disposal, dispensing and administration of medicines
- Failure to ensure staff administering vaccines were trained or authorised to do so.

GPs are advised to visit the CQC website to read its GP guidance, and to read the DDA's 2016 Quality in Practice guidance for dispensing GPs.

Dispensing practices are committed to the eFMD

The UK is committed to implementing the European Falsified Medicine Directive (eFMD). "Despite Brexit, this train has left the station," the DDA 2016 annual conference heard.

Describing the European supply chain as "leaky", Martin Sawer, director of Securmed, told the conference that EU customs had seized 27.4 million doses of falsified medicines in 2011- an almost seven-fold increase from 2007. Securmed is leading the implementation of the eFMD in the UK. And, to avoid a "public health issue" related to falsified medicines, the Department of Health had committed to implement the eFMD in the UK by 9 February 2019.

As part of this, the Department of Health has mandated that verification scanning should take place as close to the patient as possible. Mr Sawer said: "My feeling is that dispensing doctors will be expected to do their own [verification scanning] before dispensing."

In an active question time, in which DDA conference delegates expressed concerns about the workload implications of scanning at the point of dispensing, Mr Sawer was asked why all medicines, including low-cost products, were subject to the eFMD. Mr Sawer responded by saying that the preferred approach was "simplicity – all [medicines] or nothing".

He also reiterated that all parties, including dispensing entities (pharmacies, dispensing GPs and wholesalers) would be expected to pay their own costs for implementing the eFMD – a point which is hotly contested by the DDA.

Keep calm and get back to basics. There are still some good deals out there," DDA board member Dr Philip Koopowitz told the DDA 2016 annual conference in a packed session on dispensary profitability.

He told the audience that a profit can still be made and that drug companies "still want your business".

He offered the following tips:

- Discounts come and go – keep an eye on the DDA website
- Minimise losses by focusing on high cost drugs
- Invest time in checking what goes out the dispensary at a loss.

He said: "The vast majority of dispensing GPs plough their profits back into their practices to provide care and ensure practice resilience. Without dispensing profit, rural general practice is in danger."

In his presentation, Dr Koopowitz used worked examples to show how to calculate profit and loss, and reimbursement on items that are dispensed and which are personally administered. He was able to show how drugs offering no discount are automatically loss making.

Actavis provides funding for the origination and distribution of this educational supplement/newsletter. Actavis has no involvement in the writing of the content and the views expressed are solely those of the DDA.