DGazette
YOUR MONTHLY DISPENSARY GAZETTE

# News and Updates on Dispensing Doctor Issues

## Merry Christmas
## STAY SAFE

## 2021 Training Schedule- pages 9-11



news opinion articles learning & development technology offers

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# Editorial

The light is at the end of the tunnel…..but the train is struggling to collect it's shipment along the way. The added planning, strategy, and delivery services (including new SOP's) are certainly adding to the workload and the commitment needed from all GP Surgery/Primary Care staff.

However, the message of Christmas is HOPE, and that beacon is still lit, so if we can just grasp that spirit and believe that this time, like all others, will pass and that a more positive outlook awaits us.

The stamina and strength needed to accomplish the tasks ahead is, without doubt, going to stretch and challenge even further, but Christmas is the season to give and receive – so the efforts will be applauded, lives will be saved, calm will return and a time to reflect and thank those 'stoking the engine' is around the corner. Keep the wheels rolling, keep going and we wish you all a very merry Christmas and a bright New Year from all at Dispex.

Thank you!

*Jane, Linda & Claudy*

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# COVID-19
## UPDATES & NEWS ARTICLES

### GPs at 280 sites will deliver 270,000 doses of COVID-19 vaccine next week- By Nick Bostock on the 7 December 2020- GPOnline

GP practices will deliver more than 270,000 doses of COVID-19 vaccine from 280 sites set to go live from 14 December.

NHS England has confirmed that GP sites will begin to administer vaccines in the week beginning 14 December - in a first wave that would mark 'the beginning of a general mobilisation of practices from their designated sites'. At least one GP-led designated site is being set up in each of the 1,250 primary care network (PCN) areas across England.

However, GP leaders have been told that 280 designated sites will be part of the first wave - suggesting sites will go live next week in less than one in four PCN areas. Sites chosen to be part of the first wave will be contacted on 7 December by NHS England.

**COVID-19 vaccine:** Deliveries of doses of the Pfizer/BioNTech vaccine are expected to arrive on or close to 14 December, LMCs have reported, with vaccination to begin the following day. Each site will be expected to deliver 975 doses of vaccine across a 3.5-day period-suggesting that in total, the 280 sites will administer 273,000 doses of vaccine next week.

NHS England has said these sites initially will focus on patients in the over-80 cohort who are able to attend for a vaccination. Patients in this age group could also be vaccinated at one of 50 hospital hubs across England if they visit hospital for an outpatient appointment or if they are being discharged from hospital, and care home staff are also being offered vaccination at these sites. Scotland has confirmed that vaccination of patients in care homes - in the top priority group identified by the Joint Committee on Vaccination and Immunisation (JCVI) - will begin next week, but in England the government has yet to set a date, admitting that 'getting the Pfizer/BioNTech vaccine to care home residents is challenging because of the requirements for transporting it and the temperature at which it is stored'. Click here to read the full article.

### GPs will need to assess and approve each patient for COVID-19 vaccination- By Emma Bower on the 7 December 2020-GPOnline

A patient group direction (PGD) for the COVID-19 vaccine will not be in place at the start of the vaccination programme, meaning that GPs will need to assess and authorise for vaccines to be administered to each individual patient, NHS England has said. Click here to read the full source article.

### GPs to deliver second-dose COVID vaccinations in first week of January- By Nick Bostock on the 8 Dec 2020 GPOnline

GP-led sites contacted this week by NHS England are part of a first wave starting vaccination from next week, with two further waves expected to be 'stood up' before Christmas.

A letter outlining guidance for first-wave sites from NHS England primary care medical director Dr Nikki Kanani and primary care director Ed Waller says those that receive a first batch of the Pfizer/BioNTech vaccine on 14 December can expect a 'corresponding vaccine delivery for dose two on Monday 4 January 2021'.

First-wave sites that receive their first batch - a pack of 975 doses in 195 five-dose vials - on 15 December should expect a delivery for dose two on 5 January.

This confirms that patients will receive doses roughly 21 days apart - despite suggestions in earlier updates that patients may be offered a second jab 28 days after the first dose, in line with the requirement for other vaccine products that could soon be approved.

GP practices must have a 'collaboration agreement' in place by 13 December - or at the latest two days before they begin vaccination, the advice says.

The guidance also confirms plans for collection of hazardous waste from COVID-19 vaccination sites, IT arrangements, delivery of supplies, leaflets for patients, training requirements and plans for contacting patients and seeking consent.

Click here to read the full source article.

## Decoding the COVID-19 ES- Dec 2, 2020

by Practice Index in Coronavirus, COVID-19

We know that the COVID-19 ES is long and complicated! To help you get ahead of the deadlines, we've spent time reading and re-reading all the essential details to break it down into an easy to follow format. The Enhanced Service specification can be found here The 'Next Steps' letter, dated 1st December 2020, can be found here. This guidance is based on the GP contract information for the COVID-19 vaccination that DES issued on 01.12.2020.

**Deadlines-** Vaccination roll-out will not begin with fewer than 10 calendar days' notice. No later than the day before vaccination begins, practices must have in place a COVID-19 ES Collaboration agreement, signed by all practices in the PCN groups, that clearly sets out roles and responsibilities. (See further information in 'What you need to Consider'.) 23:59 7th December 2020: Practices need to have signed up to participate in the DES by emailing their CCG. Sign-up should include the name of the designated site. The designated site must have suitable internet connection for access to point-of-care systems from 8am-8pm, 7 days a week. 8th December 2020: Vaccination DES begins 31st August 2021: End of the COVID-19 vaccination programme (unless subject to earlier termination)

**Important points to note**

Practices need to ensure that suitable internet connection is available for access to point-of-care systems at the designated site. A signed collaboration agreement needs to be in place by the day before the vaccination programme begins. COVID-19 vaccination online training is now available. Further JCVI guidance will be issued about the at-risk groups. JCVI guidance on the groups may also change.

NHSE will authorise each cohort to be vaccinated in order. The physical security of vaccination supplies must be ensured, and the integrity of storage and cold chains of the same. Payment will be made on the completion of the second dose. An appointment should be made for the second dose before the first is administered. (Exceptions only in very limited and specific circumstances.)

Cohorts of patients Cohorts are to be called in order. NHSE will announce the authorisation of cohorts for vaccination (FROM THE DES):

**1**. Older adults resident in a care home and care-home workers;
**2**. All those 80 years of age (and over) and health and social care workers;
**iii.** All those 75 years of age and over;
1. All those 70 years of age and over; 2. All those 65 years of age and over; **3.** High-risk adults under 65 years of age; **vii.** Moderate-risk adults under 65 years of age; **viii**. All those 60 years of age and over; **1.** All those 55 years of age and over; and **2**. All those 50 years of age and over. (Moderate and high-risk criteria will be provided by JCVI prior to immunisation of those groups.)

**JCVI amended guidelines (02.12.2020) can be found here: 1.** Residents in a care home for older adults and their carers **2**. All those 80 years of age and over AND frontline health and social care workers **3.** All those 75 years of age and over All those 70 years of age and over AND clinically extremely vulnerable individuals***4.** All those 65 years of age and over **5.**All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and morality **6.** All those 60 years of age and over 7.All those 55 years of age and over All those 50 years of age and over * This advice on vaccination does not include pregnant women and those under the age of 16 years (see above). JCVI advises that persons aged less than 70 years who are clinically extremely vulnerable should be offered vaccination alongside those aged 70-74 years of age.

There are two key exceptions to this: pregnant women with heart disease and children (see below).

**JCVI at risk criteria**

- Chronic respiratory disease, including chronic obstructive pulmonary disease (COPD) cystic fibrosis and severe asthma
- Chronic heart disease (and vascular disease)
- Chronic kidney disease Chronic liver disease
- Chronic neurological disease including epilepsy
- Down's syndrome Severe and profound learning disability
- Diabetes
- Solid organ, bone marrow and stem cell transplant recipients
- People with specific cancers
- Immunosuppression due to disease or treatment
- Asplenia and splenic dysfunction Morbid obesity
- Severe mental illness

Patients eligible to receive the vaccination in general practice are those patients who are on the GP practice's registered patient list; are unregistered patients; or are care home workers or primary medical services workers who are registered on another primary medical services practice's list of patients, but who have been advised by the Commissioner (NHSE) that they may elect to receive the vaccination from the GP practice for convenience; and fall under the cohorts listed. (Taken from the DES.)

Vaccination will be considered outside these cohorts if given in exceptional circumstances, clinically necessary and where resources would otherwise have been wasted.

**What you need to consider:** The Enhanced Service Specification is subject to change, as the needs of the vaccination programme dictate. NHSE will make allocation decisions about vaccinations. Decision-making will need to be supported by accurate and timely information from practices about their stock, usage and ordering. Practices will be considered to jointly and severally own the vaccines supplied to the PCN. To be paid under the Enhanced Service, practices will need to participate in and comply with the Enhanced Service, including those conditions that may change. Practices will need to complete the vaccination programme doses.

### Practicalities

You will be expected to deliver vaccinations for COVID-19 as a PCN group, initially at one site (unless exceptional circumstances apply, e.g. >100k patients in the PCN). If you are not currently part of a PCN, you will need to work collaboratively with local practices to deliver the service as a PCN grouping. You will need to be prepared to deliver vaccination between the hours of 8am and 8pm, 7 days a week. NHSE will inform practices if this is required to ensure that vaccines are not wasted and to facilitate mass vaccination. **GP practices must agree to:**

- Co-operatively work with and openly, honestly and efficiently share such information as is necessary for the operation of the vaccination programme
- Respond to any reasonable requests for information that NHSE makes
- Comply with any clinical requirements including the timing of other vaccinations, e.g. flu
- Communicate with patients including communication supplementary to that provided nationally
- Have suitable arrangements for the lawful delivery of the vaccination programme and associated activities including data sharing

The COVID-19 ES Collaboration agreement must be signed by all practices in the PCN grouping and be in place by no later than the day before vaccination begins. A template will be provided on the GP contract page here

The collaboration agreement needs to cover appropriate provision for:

- How clinics are delivered and responsibility shared between the practices
- Patient record sharing, taking account of data protection legislation
- Reporting of activity, vaccine stock and available capacity
- Arrangements for patient communications including but not limited to call and recall
- Sharing and deployment of staff for efficient operation of the vaccination programme
- Financial arrangements between practices including any with external providers
- Arrangements in relation to use of the designated site
- Any sub-contracting arrangements
- A lead contact email address for onward dissemination of urgent communications
- Appropriate indemnity arrangements

**Service delivery will need to take account of:**

- Planning clinics according to expected vaccine supply
- Coordinating required trained staff
- Ordering required vaccine and consumables supply within required time frames
- Receiving and safely storing supply
- Amending clinic schedules if there is a disruption to supply and undertaking timely communication of any changes to patients

PCN groupings must agree one site that is suitable as a designated site. This process should already have been completed using guidance previously issued. The designation process must be completed so that practices can include the name of the designated site in their sign-up confirmation.

GP practices must ensure that there is sufficient and appropriate internet connection at the designated site to allow for access to point-of-care systems from 8am to 8pm, 7 days per week. If NHSE requests practices to put into effect security arrangements for the vaccine, the practice will make reasonable efforts to ensure that they are put into place as soon as possible. With this in mind, you might want to consider the physical security of the vaccine storage. You might also need to consider what arrangements you have in place for the servicing and monitoring of vaccine fridges, to ensure minimal chance of wasted vaccines. NHSE may be able to help with the loan of equipment, which will be returned to NHSE at the end of the programme for delivery.

NHSE recognises that some PCN groupings will need to use a sub-contracting arrangement to deliver the Enhanced Service. NHSE will not object to a sub-contracting arrangement where it is necessary to deliver the service, is compliant with the primary medical services contract, and the GP practice agrees to provide all relevant information to NSE when requested.

### Communications

**Practices will need to contact patients, ensuring that:**

- In addition to any national call/recall service, they write, text or call patients (as appropriate) using standard nationally determined text;

- They actively cooperate with any national call/recall service requirements; and
- They maintain clear records of how they have contacted (including 'called' and 'recalled') patients;
- To support high uptake of vaccinations and minimise vaccine wastage, that they proactively contact patients for vaccinations. This may include additional contacts over and above the call/recall requirements set out in paragraph 9.5.1(a) of the ES, where appropriate to do so. GP practices are not required under this ES to offer call/recall to care home residents,& health and social care workers. Where these patients are easily identifiable, GP practices may wish to offer call/recall.

**Clinical**

**Practices must ensure that:**

- Vaccines are not administered if contraindicated
- The clinically suitable, correct dose of vaccine is administered
- They are administered only within the period of the Enhanced Service
- Informed consent is obtained and appropriately recorded (including where consent is given by an appropriate representative, and their relationship to the patient)
- They comply with any relevant Standard Operating Procedures
- Patients complete the course of the same vaccination except in exceptional and limited circumstances
- They comply with JCVI guidance on the suitability, timing and dose schedule of vaccinations for each cohort
- They provide printed information for each patient which may include the manufacturer's leaflet or guidance provided by NHSE
- The patient is aware that not completing the course might result in ineffective protection
- That a follow-up appointment for administration of the second dose is booked before administering the first dose
- Vaccination is accessible, appropriate and sensitive to the needs of the patient

The Government has provided information about administering the vaccination where the timing of other vaccinations is a factor

**Vaccine storage**

**GP practices should ensure that:**

- All vaccines are received, stored, prepared and subsequently transported (where appropriate) in accordance with the relevant manufacturer's, Public Health England's and NHS England's instructions and all associated Standard Operating Procedures
- All refrigerators in which vaccines are stored have a maximum/minimum thermometer
- Readings are taken and recorded from that thermometer on all working days and that appropriate action is taken when readings are outside the recommended temperature Where vaccinations are administered away from a designated site (for example, at a care home), the GP practice must ensure that appropriate measures are taken to ensure the integrity of the cold chain, following any guidance issued by JCVI or Public Health England
- Appropriate procedures must be in place to ensure stock rotation, monitoring of expiry dates and appropriate use of multi-dose vials to ensure that wastage is minimised and certainly does not exceed 5% of the total number of vaccines supplied. Wastage levels will be reviewed by the Commissioner (NHSE) on an ongoing basis. Where wastage exceeds 5% of the vaccines supplied, and that wastage is as a result of supply chain or Commissioner (NHSE) fault, those vaccines shall be removed from any wastage calculations when reviewed by the Commissioner (NHSE) on an ongoing basis

**Monitoring**

**GP practices and PCN groupings delivering this ES must:**

- Sign up to receive the Primary Care Bulletin published by the Commissioner (NHSE)
- Monitor and report all activity information in accordance with the monitoring and reporting standards as published by the Commissioner (NHSE)
- Be responsible for recording adverse events and providing the patient with information on the process to follow if they experience an adverse event in the future after leaving the vaccination site, including signposting the Yellow Card service. GP practices will be expected to follow MHRA incident management processes in the case of a severe reaction.

**Payment and validation:** Payment will be at the rate of £12.58 per vaccination, and will be paid on completion of the second dose if two doses are required – a total of £25.16 per patient (two doses). NHSE does not intend to pay for a single dose administration unless in very specific and limited circumstances. This is to encourage practices to ensure that patients are called and recalled. For payment criteria, see sections 11.2 to 11.10 of the COVID-19 Vaccination DES. As is usual for an Enhanced Service, NHSE may audit claims to ensure that the practice was eligible to receive payment. **To read the full source article please click here**

# MERRY CHRISTMAS

# DECEMBER DELIVERIES

**For deliveries before the Christmas period, please submit your orders by the following dates;**

| | |
|---|---|
| *Dosette Boxes & PPE supplies:- | **18th December** |
| Controlled Drug Registers:- | **16th December** |

## Order Today:

**T: 01604 859000 E: sales@dispex.net W: www.dispex.net**

*Dosette orders placed after 18th, **may** arrive before the 25th, if not they shall arrive on the 29th

# 2021 INFLUENZA VACCINES

## 25% MEMBERS' DISCOUNT

Dispex is pleased to offer a members' only deal on Mylan's 2021 Influenza vaccine -secure next years' stock today!

Simply, login to the members' area (home page) to view their offer. If your Dispex membership has lapsed or you have mislaid your login details, please contact the Dispex Team!

**Tel: 01604 859000** **E: sales@dispex.net** **W: www.dispex.net**

# 2021 ONLINE TUTORIALS

Live dispensary with a Dispex tutor

*Book now for next year- each session is limited to 12 delegates!*

We are pleased to announce our training schedule for next year, which includes two NEW courses- **Introduction to Practice Finance** part 1 & 2 and **Business Management of a Dispensary** parts 1-3!

Each session is limited to 12 delegates, therefore we would advise that you book your teams 2021, professional learning before places sell out! Please find all course dates and descriptions below.

## NEW-Business management of a Dispensary

### BM- PART 1

This course will give delegates a clear understanding and underpinning knowledge of how a successful dispensary should be managed. To provide delegates with the correct tools to manage a dispensary profitably, without compromising the level of care patients receive. To ensure you stay within budget set by your local CCG.

**27th JAN**

### BM- PART 2

This course will give delegates a clear understanding and underpinning knowledge of renumeration, referred back and reimbursement of prescriptions. This course also covers how to maximise income from profitable prescribing, personally administered drugs, private prescriptions and monitoring of your drug spend.

**10th MARCH**

### BM- PART 3

The final part of this Tutorial series explains why a Prescribing Formulary is essential, how to improve your Dressing and Appliance ordering and why the 7-day prescribing could be beneficial to both your patients and dispensary. Also, explains the DSQS and QoF and their potential revenue, how automation/managed repeats could be a solution, managing stock and then provides top tips on maximising dispensary income.

**14th APRIL**

*Book Online- www. dispex.net*

# NEW-Intro to Practice Finance


## PF PART 1

**Understanding Practice Income**
This 1 hour session is aimed at those new to the management of a practice, who would benefit from a bitesize overview of the various income streams, including disease prevalence, enhanced services, drug payments and what affects them, including a brief outline of Open Exeter statements and how data affects income.

**20th Jan & 7th April**

## PF PART 2

**Maximising Income**
This 1 hour session is for the less experienced managers and partners, learning more about how to make the most of non-dispensing income in general practice. What to claim and how to check it is being claimed correctly, the typical pitfalls and often missed items, along with some regular expenditure items that can be reduced. How to improve income from Private work and the importance of your data to the income.

**25th Feb**

**Course times are 1-2pm**

# Controlled Drugs

## CD PART 1

By the end of this course you will have achieved an understanding of: Controlled Drugs legislation and classification, policies and SOP's, how to complete the CD Register, dealing with the receipt, supply and destruction. How to identify discrepancies, reporting or whistle-blowing. CD storage and travelling with CD's plus prescription writing requirements.

**13th Jan & 21st April**

## CD PART 2

By the end of this course you will have achieved an understanding of: Process of ordering, requisition & supplier requirements. The CD Register, patients returns recording & destruction, plus the correction of errors, ensuring safety & legal requirements.

**17th Feb**

# Drug Tariff & Endorsing

## DRUG TARIFF

This training will give you insight as to why stock control is essential to profitability. We will discuss what to look for in controlling your stock and how to implement ideas to remain in charge of it. It will help you identify more clearly any avoidable losses, as well as improving cash flow.

**17th March**

*Book Online- www. dispex.net*

# Understanding Profitability

## Part 1

**Formulary, PA s and VAT**

This course will give you insight in to why a strict Formulary is essential to profitability. Discussing Personally Administered items in more detail and basic VAT knowledge. This will help identify any avoidable losses, as well as increasing dispensary income.

**24th March**

## Part 2

**Purchasing and Concessions**

This course will provide you with some of the key skills and knowledge to successfully manage, and increase your dispensary income and improve profitability. Explaining where and how to make your buying decisions, smart purchasing and discount schemes. Also looking at concessions and how this affects profitability.

**28th Jan & 28th April**

## Part 3

**Stock Control**

This training will give you insight as to why stock control is essential to profitability. We will discuss what to look for in controlling your stock and how to implement ideas to remain in charge of it. It will help you identify more clearly any avoidable losses, as well as improving cash flow.

**24th Feb**

# How to Book

Please book online at **www.dispex.net/training** or email **training@dispex.net**

Dispex members price: **£45+vat** per delegate | Non- members price: **£60+vat** per delegate

**Course times are 1-2pm**


***" Explained well"***
- Dispenser

***"The slides were very good and I enjoyed the course being online"*** - Dispensary Lead

***" Very good content and informative"*** - Dispensary Lead

***"Good knowledge of subject"***- Dispenser

***"Course was on time & engaging***"
-Senior Partner

***"Explained very clearly, easy to follow online"*** - Dispenser

Book Online- www. dispex.net

THERE'S STILL TIME TO TOP UP YOUR 2020 PROFESSIONAL LEARNING

# DECEMBER TUTORIALS

CD Part 2
Weds 9th Dec

Profitability Part 1
Weds 10th Dec

Drug Tariff
Weds 16th Dec

CLASSES ARE RESTRICTED TO A MAXIMUM OF 12—SO BOOK YOUR PLACE QUICKLY!

**1- 2PM**

**MEMBERS: £45+VAT ***

**NON-MEMBERS: £60+VAT***

*per delegate

**CLICK HERE TO BOOK- WWW.DISPEX.NET**

*By Melissa Greeves-Dispex Tutor*

# DSQS - the abbreviation you may have heard spoken within your Practice?

## DSQS what is it, and what does it stand for?

**Introduction**

Dispensary Services Quality Scheme ('the Scheme') came into effect in September 2006, and is part of the General Medical Services (GMS) change. The annual Scheme rewards Practices for providing high quality services to their dispensing patients. Practices which sign up to the Scheme and achieve all the standards, will receive a payment for each dispensing patient.

It follows the structure of the specification of requirements for receiving dispensary services quality payments as set out in the DSQS guidance, and includes the following information:

### Overview of quality requirements

The key quality requirements of the Scheme are:

- Duty of confidentiality
- Dispensing staff must be appropriately trained and undertake continued training with annual appraisals.
- Dispensers who work unsupervised must have at least 1,000 dispensing hours work experience over the previous five years in a GP dispensary or community pharmacy, and must be trained to Pharmacy Services S/NVQ level 2
- Minimum levels of staff hours dedicated to dispensary services
- Staff with a limited dispensing role must be given relevant training and competency assessment
- Standard Operating Procedures ('SOPs') which reflect good professional practice and all dispensary procedures. SOPs must be reviewed and updated at least **once every 12 months** and whenever dispensing procedures are amended. Clinical audit and risk assessment.
- A Significant Event Monitoring Procedure must be in place.
- An annual review (DRUM) must take place of the medicines use for 10% of the dispensing list (7.5% in 2006/7).
- Assessment of performance against the criteria for payment. Practices and CCGs will wish to read this guidance alongside the specification for receiving dispensary services quality payments


This is presented to each dispensing practice as a guidance book, consisting of 28 pages. Along with Audit templates and a self-assessment form.

The scheme is voluntary and rewards organisations for providing high-quality services to dispensing patients.

Practices have to sign up annually, by 1st July, via the CCG and provide the name of the GP in the practice who is accountable for the quality of dispensing services.

Payment is based on the number of dispensing patients on your organisation's list on 1st January in the financial year to which the payment relates, as measured by the Open Exeter system. Dispensing patients are the patients for whom the organisation, or any practitioners working for them, have consent to dispense under the NHS (Pharmaceutical Services) Regulations 2005, or relevant sect-ions of the GMS and PMS regulations. The payment is still £2.58 per dispensing patient per financial year, and that hasn't changed since its inception. So, depending on your list size, is potentially a valuable source of income and often supports other services within the practice.

It is wise to allow protected time to plan for your audit and audit outcomes to ensure these are submitted by the deadline of 1st January. The self-assessment form should be submitted by 2nd March to ensure full payment.

Dispex understands the importance of your time and income, particularly at the busiest time of the general practice Year End. We have therefore, developed a training Tutorial covering all aspects of the DSQS. This will ensure you have clear guidance and support, and enable you to achieve the full payment, which is invaluable to your practice. Check the Tutorial Training Schedule on our website for details.

To support this new DSQS training, we are also launching a complete range of SOP Services to provide all the processes and requirements for the DSQS and CQC regulatory inspections, in various formats depending on your needs. These will include Templates, Completed policy SOP's and a bespoke SOP Writing Service - particular to your own Practice conditions and constraints. Further details will follow on the Dispex website **www.dispex/SOPS**

# DISPENSARY MANAGERS

## Time to make a resolution for change

*By Gary Paragpuri, CEO, Hub & Spoke Innovations*

Two years ago, my business partner Ryszard Cygan and I made a visit to a dispensing surgery that was interested in finding out more about the Pharmaself24 and how a medicines collection point would work for their practice.

We enjoyed a positive conversation with the team there, and it was clear that automating medicine collection could help them realise gains in their productivity and patient satisfaction. After handshakes and goodbyes, Ryszard and I went on our way, the door left ajar for a new member of the Pharmaself24 family.

And that's the way it stayed until this summer when, in the midst of a pandemic, the door swung open again. We have since supported the practice with planning permission and installation of a smart new machine, ready for the Christmas season.

What struck us about this particular situation were the comments the practice team made as they stood listening to the machine's robotic arm whirring busily behind the brushed metal façade and gently depositing another medicine bag in the drawer below.

## "Why on earth didn't we do this before?"

That prompted us to think of all the possible answers to that question and we concluded there were three key elements involved.



Firstly, a doctor's focus will always be on the health and wellbeing of their patients. And rightly so – but that can mean a smaller proportion of the team's energy is available for tricky strategic questions about how to improve the patient experience or bring greater efficiency to the dispensing process.

This leads into the second point, which is that when people are busy, they typically only deal with what's right in front of them. If something doesn't get pulled into your line of vision, added to your to-do list, or form part of your regular workflow, then it can easily fall by the wayside. Unless things change.

Which leads into the third point: decisions can be heavily influenced by external factors. The outbreak of the pandemic pushed many pharmacies and dispensing practices onto the back foot, prompting them to think hard about how best to support patients and their changing needs, particularly around social distancing.

So, as we head into a (hopefully happier) new year, perhaps it's time to get on the front foot and flip these three answers on their head – to resolve to be more strategic, to think outside of your box, and to take that leap of faith rather than wait to be pushed.

Hub&Spoke INNOVATIONS
SECURE COLLECTION TECHNOLOGY

The Pharmaself24 is an automated prescription collection point that lets your patients pick up their medicines at a safe distance at any time of the day or night. No queues, no waiting, no fuss. For more information please visit pharmaself24.co.uk

DISPEX WEBINAR

# Profiting through technology in a changing world

## Thursday 4th February 1pm
## FREE Webinar

From coping with social distancing to managing the threat from internet pharmacy, dispensing practices are having to rise to a range of challenges relating to patient service and profitability.

This webinar, presented by Hub & Spoke Innovations, provides an opportunity to explore how automated medicine collection is enabling practices across the UK to move with these changing times.

**Key areas for discussion include:**

- **Patient experience**
  - Providing convenience and choice through 'self-service' prescription collection
  - Retaining patients and building loyalty in the face of growing internet pharmacy threat
  - Supporting social distancing for vulnerable or anxious patients
- **Dispensing efficiency**
  - Avoiding queues and creating a calmer prescription collection environment
  - Reducing average time/cost to distribute each item
  - Freeing up staff capacity for more valuable tasks

To find out more about how technology can help your dispensary preserve patients and profitability, register to attend this free webinar to be held on 4th February at 1pm.

Register at **dispex.net/hs-tech-webinar**

# MARKET PRICED GENERICS

## (Including Generics ABOVE the Drug Tariff)

## DECEMBER 2020- EXAMPLE

| Product | Pack | Drug Tariff | Tariff minus clawback | Market based generics | Cost Diff |
|---|---|---|---|---|---|
| Zonisamide 100mg Caps | 56 | £ 6.94 | £6.16 | £ 53.95 | -£47.79 |
| Omeprazole 4mg/ml Powder for Oral Susp (20mg/5ml) | 75ml | £ 178.35 | £158.41 | £ 178.34 | -£19.93 |
| Levothyroxine 25mcg Tabs | 500 | £ 27.32 | £24.27 | £ 35.49 | -£11.22 |
| Omeprazole 2mg/ml Powder for Oral Susp (10mg/5ml) | 75ml | £ 92.17 | £81.87 | £ 92.17 | -£10.31 |
| Pericyazine 10mg/5ml Syrup | 100ml | £ 82.80 | £73.54 | £ 82.78 | -£9.24 |
| Pericyazine 10mg Tabs | 84 | £ 72.00 | £63.95 | £ 72.49 | -£8.54 |
| Moxonidine 200mcg Tabs | 28 | £ 1.34 | £1.19 | £ 9.19 | -£8.00 |
| Enalapril 20mg Tabs | 28 | £ 2.22 | £1.97 | £ 9.95 | -£7.98 |
| Moxonidine 400mcg Tabs | 28 | £ 1.41 | £1.25 | £ 8.49 | -£7.24 |
| Desmopressin Nasal Spray | 6ml | £ 18.08 | £16.06 | £ 22.69 | -£6.63 |

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DISPEX DISPENSING FOR PROFIT

## Practice Managers creating a collective voice on a national stage

Frustrated by the lack of voice for practice managers – and concerned about the stresses being placed on the profession because of COVID-19 – a group of practice managers have set about forming an organisation that aims to be the positive voice for all managers in general practice.

Kay Keane (Alvanley Family Practice), Robyn Clark (Kingswood Health Centre), Jo Wadey (St Lawrence Surgery) and Nicola Davies (The Roseland Surgeries) are aiming to raise profile of the profession as well as ensuring PMs become a central voice in policy making discussions. It's also hoped some form of centralised accreditation process can be developed that further bolsters the PM role.

Robyn Clark, Practice Manager at Kingswood Health Centre and one of the founding members of the organisation told us that now is the time to act, given morale amongst PMs is at an all-time low.

"There has always been variation across the UK in how PMs feel they are treated in their job. Many of us feel valued, supported by our Partners and our teams, but sadly there are many who experience quite the opposite. We've always highlighted that it is a lonely job nobody else does what we do within our organisation and it comes with a lot of responsibility and accountability, so can feel very isolating.

"COVID-19, in my opinion, has brought out the best in PMs, but the worst in the government and the NHS powers-that-be. Whilst we have implemented massive changes to the way we work by engaging with our teams, supporting them and being a conduit of information, we have had none of these things come down from above. The media have found out what we're going to be doing before our CCGs or LMCs even have."

Robyn continues: "And then to top it all off, the New to Partnership Scheme, informally known as the 'Golden Hello' which for many was seen as finally some recognition for our role – was taken away from us. With no formal communication or explanation. In fact, on asking, one of us was told that we were being excluded because we 'aren't a registered profession'. Whether you were interested in partnership or not – and many aren't, which is completely fair enough–this still felt like a massive slap in the face. To have clinical roles included that have either zero experience of working in general practice, or zero experience of RUNNING general practice, but not practice managers – who are literally the glue that holds the surgery together – was too much.

"Morale seemed to be at an all-time low, and a poll that we conducted on Practice Index showed that 55% of respondents were thinking of leaving the profession. On the national Facebook group and Practice Index Forum there were calls for a union to be formed and for representation at a higher level. Letters and petitions were drafted and signed to get the attention of the government and the media about our grievances. It felt like there was momentum growing and it felt like the right time to really do something about it."

**Online meeting attracts hundreds**

The first online meeting of the group, which took place on Wednesday 25 November 2020, attracted hundreds of colleagues to discuss ways to amplify their collective voice and it was clear there is overwhelming demand for a voice and representation at a higher level.

"We have all been in those circumstances where a service spec comes down from the CCG or NHS and we immediately think, 'they have no idea how this is going to work in practice'," explains Robyn. "WE are the people that hold this knowledge – and we need to be at the table talking these issues through before that spec gets released.

"We also want recognition as a profession – there are literally tens of thousands of us in the UK. Yes, we come in many different guises but there is more that links us than separates us. As a result, membership of a professional body and / or a form of accreditation also came out of the meeting as something we were all keen on."

Robyn adds that many also asked for support, education and training in their role. "Whether this is badged as a union we aren't sure of yet but union or not, we would hope to be able to provide these things to our members."

Other key themes to come out of the online launch meeting included that fact PMs have roles that are incredibly varied – but they all come back to one common, uniting theme:  the work of PMs has a tremendous impact on primary care.

# CONTINUED

Practice Managers creating a collective voice on a national stage

*By Practice Index*

"We all feel that now is the time for us to stand up and be counted," says Robyn. "The support on social media, via the meeting chat, from emails we've had from people volunteering to get involved.....…it has been amazing."

**Made by PMs for PMs**

When asked why the likes of the Practice Management Network can't take this job on, Robyn responds: " We found that support out there for PMs is already really fragmented. When asked in the Facebook group not long ago how many people had heard of PMN or the NAPC, there were a lot of managers who hadn't. There are also other organisations out there who claim to represent us, who we've either never heard of or who don't actually seem to be made up of jobbing PMs.

"Crucially, we wanted to set something up that was made by PMs for PMs, which has the opportunity to be supported by these other organisations. If they want to get involved of course! – but whose primary focus was on furthering the agenda that PMs from across the UK have voiced."

This independence also provides us with the ability to move rapidly and build on the momentum that has been generate-d over the last few days, since it was agreed to forge ahead with plans.

"The last few days have been so exciting!" says Robyn. "We've had #PMpower trending on social media! We've met with the BMA and GPC to discuss how we can support each other, and they are very keen to get on board. Wessex LMC, Practice Index and the NAPC have been supporting us with communications and helping us progress the set-up side of things and we've already met with Heather Simpson, Senior Programme Lead at NHS England and NHS Improvement. We are meeting with the RCGP next month and have also had messages of support from Nikki Kanani, who we are also looking to engage with.

"Our next step is to formalise the name of our organisation and get a website and information set up. We then are planning to hold another virtual meeting on 16 December with prospective members to update them on our progress and aim to formalise our structure. There's a lot to do but we are pretty fired up about it!"

Robyn adds that the conversations that have taken place so far have been positive and that a paper is being drafted to propose how the organisations engage and how PMs can get that all-important seat at the table.

"Dr Krishna Kasaraneni is really supportive. 'I can't even do half a day's work without my practice manager' were his words! Nikki Kanani has messaged us in sup-port of what we're doing and the contacts at NHS Eng-and who we've spoken to are backing us. We're feeling really positive and feel that we can really make a difference."

Finally, responding to being asked why there's so much positivity around the movement and why the founders think they can succeed, Robyn says: "We are a bunch of opinionated, mouthy women! In all seriousness, we are four PMs who are really passionate about what we do. We also really care about the wellbeing of our peers and colleagues and we have hated to see so many messages from PMs struggling with the current situation and the stresses, even before COVID-19 arrived on the scene.

"We channel that passion into activity – and we are pretty tenacious with it too. Considering this all started only three or four weeks ago, the momentum we've built up so far astounds me. And the support we have behind us is also key to our progress – so keep it coming!"

On that note, a thread on the Practice Index Forum has been set up for practice managers to share their thoughts, ideas and feedback on this positive action that's being taken. Please do join the conversation and help provide PMs with the voice that's very much needed. #PMpower

To read the source article click here

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# DON'T CANCEL CHRISTMAS FOR YOUR STAFF

**While we may not yet have full details of the lockdown/Tier rules for December, it is clear that this festive season will be very different from normal years. Practices may be gearing up for vaccination programs and although everyone will want to look after the wellbeing of their staff, it is highly unlikely that a normal staff Christmas party will be possible. But that doesn't mean that you can't spread a little seasonal cheer in other ways.**

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It is relatively well known that the cost of entertaining staff at a seasonal event is not taxed as a benefit in kind provided certain conditions are met. HMRC is extending the staff parties concession this year to apply to the costs associated with virtual parties in the same way that it would for traditionally held, parties. So, the cost of providing food, entertainment, equipment and other expenses which may be incurred in hosting a virtual event, will be exempt, subject to the normal conditions.

Remember, the intention of the exemption is to allow for costs of provision which are generally incurred for the purposes of the event itself, and that the event and food etc. is available to all employees. As with a traditional party, the cost of the event (or events, if spread across the year) must not exceed £125 plus VAT.

It is important to remember that HMRC will still apply the rules strictly: for example, giving out restaurant vouchers to staff for £100 would not fall within the exemption. Vouchers that can be exchanged for goods and services (non-cash vouchers) are treated as a benefit in kind, so income tax and NICs are due on the taxable value- although practices could choose to bear this cost through a PAYE settlement agreement with HMRC.

While such gifts to staff are generally taxable, a 'trivial' benefit can be given to employees without a tax or NIC charge arising provided the all following conditions are satisfied:

1. The cost of providing the benefit does not exceed £50
2. The benefit is not cash or a cash voucher (eg a premium bond)
3. The employee is not entitled to the benefit as part of any contractual obligation (including under salary sacrifice)
4. The benefit is not provided in recognition of particular services performed by the employee as part of their employment duties (or in anticipation of such services).

Where the above conditions are not satisfied, the full cost of the benefit (not just excess over £50) is taxed in the normal way, subject to any other exemptions or allowable deductions. While VAT can be recovered on the purchase of gifts, VAT must be accounted for when these gifts are given away, unless the total cost of any gifts given to that person in any twelve month period is less than £50 (excluding VAT).

If you do decide to say thank you to your staff this Christmas, the good news is that the cost of a staff virtual party and the value of staff gifts is usually a tax deductible expense for the practice.

**However you end up spending the festive season this year, the team at BDO wish you a happy one.**

## FOR MORE INFORMATION:

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## Pharmaceutical Negligence

As an Expert Witness in medical and pharmaceutical negligence and in particular claims regarding medication errors as well as faulty techniques the Personal Administration of vaccines by community pharmacists, I have seen a surge in claims by patients alleging pharmaceutical negligence sometimes with a contribution of medical negligence. In today's litigation society with the two on going prospective immunisation campaigns that of flu and COVID-19 unfortunately this topic is likely to be relevant to healthcare professionals.

My lecturer in dispensing at Bath University John Harris final words to his pharmacy students ***'Ladies and Gentlemen you are the last stop before the Coroners Court.'***

A patient who wishes to recover damages for personal injuries has to prove: -

**A.** That the defendant owed them a duty of care.

**B.** That the defendant was in breach of that duty.

**C.** The they have suffered damage as a result of that breach.

**D.** That the damage was reasonably foreseeable in all the circumstances.

### Duty of Care

A duty to take reasonable care arises when the defendant could have reasonably foreseen a risk of the claimant being injured by their conduct.

### Breach of that duty

A breach of the duty of care occurs when one fails to fulfil his or her duty of care to act reasonably in some aspect... Generally, if a party does not act in a reasonable manner to prevent foreseeable injuries to others, the duty of care is breached.

### Damage as a result of the breach

The claimant must show the defendant's wrongdoing was a cause, though not necessarily the sole or dominant cause of their injuries. In general, a defendant who commits a wrong takes their victim as they find them. It is no answer to a claim for damages to say that the victim would have sustained no or less injury if they had not suffered from some pre-existing condition.

### Foreseeable Damage

The type of injury which they had suffered must be reasonably foreseeable in the sense that a reasonable person would have foreseen the type of injury as being likely to follow from the defendant's breach of duty.

### Application of the law to pharmacists

It is clear that a pharmacist is obliged as a supplier of medicinal products to take reasonable care to: -


**a)** Ensure that the correct medicinal products are supplied.

**b)** Warn patients (or their representatives) of the possible medicinal dangers or adverse effects of the medicinal products.

**c)** Ensure that patients are instructed as to the correct dosage.

**d)** In the case of Personal Administration that both the technique and the correct product is administered. that a full and appropriate history is taken and the risks and side effects are explained to the patient.

Failure to take reasonable care in the discharge of any of these tasks will render the pharmacy/pharmacist (and the prescriber) liable to legal proceedings for breach of professional duty. The application of these principles was demonstrated by a consideration of the following two reported cases.

### Dwyer v Roderick and others (1983)

The patient (Dwyer) sued the pharmacy company Cross Chemist (Banbury) Ltd and Doctor Roderick and his partner Doctor Jackson. The appeal court found that the pharmacy and the doctor were both liable.

### Prendergast v Sam and Dee Ltd Kozary and Miller (1989)

The patient (Prendergast) sued the pharmacy company (Sam and Dee Ltd) the pharmacist (Kozary) and the doctor (Miller). The court found all three defendants liable.

Further and better details of these cases may be found in Appendix 5 BMJ Volume 297 13th August 1988 K.Mullen University of Ulster relating to liability of pharmacies following prescription medication errors by General Medical Practitioners and pharmacists.

Hopefully Dispex Gazette readers will never need the services of an Expert Witness but for any legal or forensic matters Dispex members are entitled to a free initial consultation with advice from Nigel Morley. He is considered the leading pharmacist authority advising dispensing doctors on the Pharmaceutical Regulations 2013.

Nigel can be contacted by email **office@nvmholdings.com**, through the Dispex office or if somebody is knocking at the door **07725 168453.**

# Brand Comparisons -Information from Spotdispensing.com


Some CCGs are starting to look at Inhaled Corticosteroids (ICS) as they continue their squeeze on drug costs. We have produced the following table to help you make your decisions. There has been a move away from ICS as clinicians try to reduce overall steroid load. This may mean less prescribing of ICS on their own and greater prescribing in combination with LABAs.

CCGs will be looking at the cheapest alternatives and Kelhale (which is only available as an MDI (Metered Dose Inhaler) in the 50 and 100 dose) may be suggested as their first choice.

Our previous article on Greenhouse gases and MDIs, would suggest a move to DPIs (Dry Powder Inhalers) and this will encompass ICS. The choices for DPIs is limited and the Breathe-actuated inhalers have the same detrimental effect on Greenhouse gases as MDIs.

Choose wisely.

| Prescribe | Manufacturer | Doses | Basic Price | Profit |
|---|---|---|---|---|
| **BECLOMETASONE** | | | | |
| **50 MDI** | | | | |
| Clenil | Chiesi | 200 | £3.70 | £0.81 |
| Kelhale | Cipla | 200 | £5.20 | -£0.58 |
| Soprobec | Glenmark | 200 | £2.78 | £0.86 |
| Qvar MDI | Teva | 200 | £7.87 | £1.48 |
| **100 MDI** | | | | |
| Clenil | Chiesi | 200 | £7.42 | £1.62 |
| Kelhale | Cipla | 200 | £5.20 | -£0.58 |
| Soprobec | Glenmark | 200 | £5.57 | £1.72 |
| Qvar MDI | Teva | 200 | £17.21 | £3.24 |
| **200 MDI** | | | | |
| Clenil | Chiesi | 200 | £16.17 | £3.53 |
| Soprobec | Glenmark | 200 | £12.13 | £3.74 |
| **250 MDI** | | | | |
| Clenil | Chies | 200 | £16.29 | £3.55 |

| Prescribe | Manufacturer | Doses | Basic Price | Profit |
|---|---|---|---|---|
| Soprobec | Glenmark | 200 | £12.22 | £3.77 |
| **DPI 200** | | | | |
| Easyhaler Beclometasone | Chiesi | 200 | £14.93 | £0.12 |
| **Breathe-actuated inhalers 50** | | | | |
| Qvar Easi-Breathe | Teva | 200 | £7.74 | £1.46 |
| Qvar Autohaler | Teva | 200 | £7.87 | £1.48 |
| **Breathe-actuated inhalers 100** | | | | |
| Qvar Easi-Breathe | Teva | 200 | £17.21 | £3.24 |
| Qvar Autohaler | Teva | 200 | £17.21 | £3.24 |

NOTE: The recommended total daily dose of Qvar is lower than that for current beclometasone dipropionate containing products and should be adjusted to the needs of the individual patient.

**BUDESONIDE**

**DPI 100**

| | | | | |
|---|---|---|---|---|
| Easyhaler Budesonide | Orion | 100 | £8.86 | £0.07 |
| Pulmicort Turbohaler | AZ | 100 | £14.25 | -£1.59 |
| **DPI 200** | | | | |
| Easyhaler Budesonide | Orion | 100 | £17.71 | £0.15 |
| Pulmicort Turbohaler | AZ | 100 | £14.25 | -£1.59 |
| Budelin Novolizer device + cartridge | Mylan | 100 | £14.86 | -£1.66 |
| Budelin Novolizer -refill | Mylan | 100 | £9.59 | -£1.07 |
| **DPI 400** | | | | |
| Easyhaler Budesonide | Orion | 100 | £17.71 | £0.15 |
| Pulmicort Turbohaler | AZ | 100 | £14.25 | -£1.59 |
| Pulmicort Turbohaler PI | AZ PI | 100 | £14.25 | -£0.52 |
| **CICLESONIDE** | | | | |
| **80 MDI** | | | | |
| Alvesco | Covis | 12 | £32.83 | -£3.67 |
| **160 MDI** | | | | |
| Alvesco | Covis | 60 | £19.31 | -£2.16 |
| Alvesco | Covis | 120 | £38.62 | -£4.32 |
| **MOMETASONE** | | | | |
| **DPI 200** | | | | |
| Asmanex Twisthale | MSD | 30 | £15.70 | -£0.66 |
| Asmanex Twisthaler | MSD | 6 | £23.54 | -£0.98 |

| Prescribe | Manufacturer | Doses | Basic Price | Profit |
|---|---|---|---|---|
| **DPI 400** | | | | |
| Asmanex Twisthaler | MSD | 30 | £21.78 | -£0.91 |
| Asmanex Twisthaler | MSD | 60 | £36.05 | -£1.51 |
| **FLUTICASONE** | | | | |
| **MDI 50** | | | | |
| Flixotide evohaler | GSK | 120 | £6.53 | £0.05 |
| Flixotide evohaler PI | GSK PI | 120 | £6.53 | -£0.70 |
| **MDI 125** | | | | |
| Flixotide evohaler | GSK | 120 | £21.26 | £0.17 |
| Flixotide evohaler PI | GSK PI | 120 | £21.26 | £5.11 |
| **MDI 250** | | | | |
| Flixotide evohaler | GSK | 120 | £36.14 | £0.30 |
| Flixotide evohaler PI | GSK PI | 120 | £36.14 | £10.05 |
| **DPI 50** | | | | |
| Flixotide accuhaler | GSK | 60 | £4.00 | £0.03 |
| Flixotide accuhaler PI | GSK PI | 60 | £4.00 | -£0.41 |
| **DPI 100** | | | | |
| Flixotide accuhaler | GSK | 60 | £8.00 | £0.07 |
| Flixotide accuhaler PI | GSK PI | 60 | £8.00 | -£0.81 |
| **DPI 250** | | | | |
| Flixotide accuhaler | GSK | 60 | £25.51 | £0.21 |
| Flixotide accuhaler PI | GSK PI | 60 | £25.51 | £7.77 |
| **DPI 500** | | | | |
| Flixotide accuhaler | GSK | 60 | £43.37 | £0.36 |
| Flixotide accuhaler PI | GSK PI | 60 | £43.37 | £12.13 |

PHE have various FREE downloadable resources-click here to view

# PRACTICE MANAGERS

The Institute of General Practice Management

*By Nicola Davies- Practice Manager*

A few weeks ago, you might have seen a blog I had written (and a podcast) on the Practice Index website about low morale and whether we needed a 'call to arms.' We know that the role of the Practice Manager can be incredibly lonely and some of you might know that I often refer to myself as "everybody's friend and nobody's best mate". We were horrified to find that 55% of Practice Managers were considering leaving their jobs in the next 12 months – this is an absolute crisis, and we need action.

A small group of us got together with help from Practice Index and we held a nationwide webinar to see what we could do. We not only need somewhere to go for support and development, but also we need a place at the 'top table', a voice that will be listened to, before policy comes down from on high with an expectation that we will deliver the solution without any prior input!

The Institute of General Practice Management has now been formed and we're now putting meat on the bones of the organisation.

As a Practice Manager with over 35 years' in Primary Care, I have been through many policy changes and been expected to manage a business without much in the way of support. For the last 5½ years, I have managed a disp-ensing practice in rural Cornwall. Having never worked in a dispensing practice before, this threw a real challenge at me - it is like having another business tagged on to the one I'm already running!!

Key to success is a good Dispensary Manager – or at the very least, an experienced dispenser who can help ensure you sign up to all the manufacturer discount schemes, buy stock at the right price from the right wholesaler and maintain (or increase) your dispensing fees – which all adds to profit. Sales reps from suppliers are only too keen to offer help and support – but let's be honest, they want your business so they'll do what they can to keep you, and they're very good at making sure you're signed up to the approp-riate discount deals.

However, I think this is the kind of 'nuts and bolts' of the dispensary and with a DM on board, I try not to get too involved in the actual processes. What I'm interested in is money – cold, hard cash that means my dispensary is not only paying for itself, but also earning the business a healthy profit, and keeping us afloat.

My stress levels are not helped by the fact that our PPA reimbursement statement comes out two months in arrears, so tracking dispensary income versus expenditure isn't straightforward.

When you add this side of the business onto the general running of the practice, it can often feel like a heavy burden and one which we all (DMs included) take very personally. It is vital that we have mechanisms for support, someone that we can refer to for advice and guidance, and often a solution when we can't see the wood for the trees.

For Practice Managers running dispensing practices, some of our questions just cannot be answered by another PM who isn't in the same position. So, look to your PM colleagues within your county - chances are, they're in the same boat. Throw out questions to Dispex, to the DDA, to Practice Index. The key message here, is don't get to a point where you won't ask the question, don't let that one worry snowball into something far greater than it needs to be.

Support is out there, you are not alone! Nicola.

IGPM
Institute of General Practice Management

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-

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# Phase 4 information for GP practices

In EPS Phase 4, patients without a nomination will be given a token (patients may refer to these as 'paper copies' of their prescription) by the GP practice. Patients can take these tokens to any pharmacy in England.

All GP practices using TPP SystmOne and EMIS Web have now been enabled for Phase 4.

For most practices, the move requires minimal action, but support materials and a checklist are available on this page.

Your system supplier can provide information specific to your prescribing system, and you can contact your CCG EPS lead for further support if required.

Phase 4 is not yet available for national roll-out with Vision and Microtest.

## Benefits for prescribers include:

- almost all prescriptions will be processed and signed electronically - in most cases, over 95% of your prescriptions will be processed this way and only a small proportion will be hand-signed
- one main process for prescriptions will lead to a more efficient, faster and secure service
- if a patient without a nomination loses their token, it can be easily reprinted - there is no need to re-issue the electronic prescription
- it is also possible to track more prescriptions using the EPS Prescription Tracker

### Patients who already have a nomination

Millions of patients already have a nomination. Their nomination will remain valid and their prescriptions will still be sent electronically to their nominated dispenser.

### Patients who do not have a nomination

If a patient does not have a nomination, their prescription will also be sent electronically in Phase 4. You will need to print a token which should be given to the patient, the patient's representative or their prescription collection service.

The token contains a unique barcode and you should advise patients to take it to a pharmacy or Dispensing Appliance Contractor (DAC) of their choice in England. The electronic prescription will remain on the NHS Spine until dispensing staff scan the token to retrieve it and begin the dispensing process.

EPS Phase 4 prescriptions are not affected if a patient sets or changes an EPS nomination after they have been issued.

### Phase 4 prescriptions and tokens

Patients without an EPS nomination will automatically have their prescriptions sent electronically.

Patients with a nomination may also choose to have a Phase 4 prescription if they don't wish to use their nomination for that prescription.

A token (patients may refer to this as a 'paper copy') should be printed for all Phase 4 prescriptions.

In exceptional circumstances, where it is not possible for the patient to collect a token – see guidance for using EPS in remote consultations.

Tokens contain the same information as an FP10 such as the medications prescribed, quantity, dosage and instructions. However, as this is not the legal prescription, you do not sign this by hand.

The token is used by the dispenser, such as a community pharmacy or DAC, to scan the barcode to retrieve the prescription from the NHS Spine.

### Repeat Dispensing (RD) or batch prescribing Electronic

Electronic repeat dispensing (eRD) for patients with a nomination will not be affected by Phase 4.

If a patient is part way through a paper-based RD batch when Phase 4 is switched on, that will continue on paper until the batch is complete and the final issue dispensed. If a new batch is prescribed after this, it will be issued using eRD.

In Phase 4, eRD prescriptions for patients without a nomination are issued in the same way as eRD for those with a nomination. Guidance on how to cancel items on eRD prescriptions is available from your prescribing system supplier.

Unlike a paper-based RD batch, patients without a nomination will receive just one token which will cover the entire regime. They will need to present this to a dispenser at each issue.

Dispensers have access to the EPS Prescription Tracker and can use this to check the dispensing intervals of any previous issue and that these are appropriate for the prescribed dose and quantity. Patients can also speak to their local pharmacy or DAC about leaving their token with them if they would like them to dispense future issues in the batch.

If an eRD regime has been issued whilst a patient does not have a nomination, then all issues will remain non-nominated, even if a nomination is set during the regime.

## Dispensing practices

If you are a dispensing practice and do not use EPS in your dispensary, you may need to check your system configuration to ensure your dispensing patients continue to receive FP10s that you are able to dispense. Guidance is available from your system supplier.

### Exceptions

There are only a few scenarios where a prescription won't be sent electronically and a paper hand-signed prescription will need to be produced.

To read the full source article please visit
https://digital.nhs.uk/services/electronic-prescription-service/phase-4/prescriber-information


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## COVID-19: Are we really doing this then?

In the latest twist, it appears that in general practice, despite urgent comms in the last few weeks, we aren't going to need to be ready to deliver the COVID-19 vaccine programme from 1st December – or are we?

Having read the letter sent out last week to NHS trusts, it appears at first glance that we're not going to be needed in the first phase of the 2020 campaign, if and when it arrives- unless we're going to need to vaccinate some of our care -home patients and over 80s; then we might be vaccinating more than it appears at first glance.

We're busy gearing up for a full-blown vaccination campaign. Some brilliant technological solutions are being offered, but I'm not sure how they're going to fit in with the national apps and booking process. I feel quite undecided about what is the best way to go, and none of the other PMs in our PCN seem any more confident than I am.

I can't see any way around this, other than planning for it to happen – after all, even if we don't end up administering the super-low temperature vaccine, as soon as an alternative becomes available, we'll most likely be first and foremost. Hence, it's not a case of if, but when.

I feel in some ways strangely sanguine. Now that the solution of a vaccine can be seen just over the horizon, I'm ready for the challenge that 2021 will undoubtedly bring. 2020 has been hideous, but a vaccine heralds the start of the return to normal.

Having delivered a socially-distanced flu campaign, which was incredibly successful, I feel confident about our ability to provide a COVID-19 vaccination programme too. I'm not optimistic that the payment is a generous settlement, but if we break even on the campaign, I'll be happy. I want to be a part of the incredible team that has delivered patient care despite intense challenges. I want my team to feel the deep appreciation I have for them, both individually and collectively. Their professionalism, support and never-ending effort this year have proved just what incredible humans they are. I'm in awe of what general practice has achieved in 2020.

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From a predominantly face-to-face organisation with limited technical support, to becoming a mainly technological consultation system within a couple of weeks, what we've achieved across general practice can't be underestimated.

So I say, "BRING IT ON!" Whatever we need to deliver, we will do, at scale, efficiently and with quiet and unassuming effort.

We'll do this because the nation needs us to. Our patients need us, and never since the foundation of the NHS in 1948 has there been such a threat to the health of the nation.

So, onward and upward: now to organise clinics, to check operational facilities for nursing-home vaccinations and to keep an eye on the deluge of emails. Together we'll make sure our staff are ready, as they are each day, to do the very best they can for every one of our patients, always.

Click here for the source article.


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Initially working within the NHS for 9 years, qualifying as a registered general nurse (RGN) and registered psychiatric nurse (RMN), before moving into the Pharmaceutical/Healthcare industry in 1991, and securing my ABPI in 1992.

Key experience, knowledge and customer interface for the last 20 years has been within the dispensing Doctor and pharmacy sectors, where nationally I managed the business through dispensing doctor's and led successful sales teams.

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- Access to 3 – 6 months prescribing and purchasing data, which would need to be within a usable format
- Prescribing and purchasing review of the agreed number of most prescribed/high-cost products through the dispensary, for example: The top 5 products prescribed, purchased and dispensed
- Bespoke "Current v Potential" prescribing NHS spend and profitability report on the above number of products, produced and presented, via a PowerPoint presentation, to the key personnel within the practice
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## US FDA approves Roche's Xofluza to prevent flu spreading in families. By Richard Staines 24.11. 20

**The FDA has approved a new use for Xofluza (baloxavir marboxil) from Roche's Genentech unit, to prevent people developing flu after coming into contact with an infectious person.**

Xofluza has already been on the market for two years, and already had licensed uses to treat uncomplicated flu and those at high risk of complications.

With this third indication, Xofluza has become the first single-dose medicine approved for this new use also known as post-exposure prophylaxis. This provides a more convenient alternative to older drugs such as Roche's own Tamiflu (oseltamivir), which is taken once daily for 10 days in this indication.

Approval was based on the phase 3 BLOCKSTONE study, recently published in the New England Journal of Medicines, which compared Xofluxa with placebo as a preventive treatment for household members who were living with someone with flu. Xofluza showed a statistically significant prophylactic effect on influenza after a single oral dose in people exposed to an infected household contact.

The proportion of household members 12 years of age and older who developed influenza was 1% in participants treated with Xofluza and 13% in the placebo-treated group.

Xofluza was well tolerated in this study and no new safety signals were identified.

The most frequently reported adverse events occurring in at least 1% of adult and adolescent influenza patients treated with Xofluza included diarrhoea (3%), bronchitis (3%), nausea (2%), sinusitis (2%), and headache (1%).

It's hoped that the new indication could take the pressure of health systems that are struggling to cope with the extra workload caused by the COVID-19 pandemic.

Serese Marotta, chief operating officer at Families Fighting Flu, said: "The flu is a serious illness that burdens households and sickens millions across the U.S. every year.

"As we are about to enter a flu season within a global Covid-19 pandemic, we welcome Xofluza as a single-dose flu medicine to be used preventively after exposure to flu."

Genentech is in talks with the FDA to develop Xofluza for acute uncomplicated influenza in otherwise healthy children (one to 12 years of age) and for the prevention of influenza in the same age group who have been exposed to influenza. Xofluza is currently not approved for use in this population. Click here for the source article.

## Free flu vaccinations rolled out to over 50s from December- By Department of Health and Social Care

People aged 50 to 64 will get free flu vaccine from 1 December as part of expanded flu vaccination programme this winter.

- **Individuals will be able to get free flu jab from their GP or pharmacist**
- **Centrally secured supply of vaccines available to GPs and pharmacies for newly eligible group**

Adults over the age of 50 will be able to get their free flu vaccine from 1 December in the next phase of this year's expanded flu vaccination programme, the government has confirmed.

Individuals aged 50 to 64 will be able to get a vaccine from their GP or pharmacy. This significant new group can now be included in the flu programme, with the initial phase of flu vaccinations well under way.

Flu vaccine uptake is higher in all vulnerable groups except pregnant women compared with this time last year. Provisional data published by Public Health England on Thursday 20 November suggests 72.9% of those aged 65 and over, 45.0% of 2 year olds and 46.8% of 3 year olds have had their vaccine.

GPs, trusts and pharmacists can order additional stock to vaccinate this new group from the centrally secured government supply of over 7 million vaccines. Click here to read the full source article.

## 'Meet the Specialists' improving early diagnosis Q&A -By GatewayC

Missed our free GatewayC webinar on Improving Early Diagnosis? Watch our recording here.

In this webinar, GatewayC met Dr Anthony Cunliffe, Joint National Lead Macmillan GP Adviser, and Dr Ben Noble, East Midlands Cancer Alliance and Cancer Research UK GP Cancer Lead, who answered key questions from our audience. **These questions included:**

- If patients don't meet the two-week wait criteria, can you still refer if you have clinical concerns?
- Do you inform patients that they are on an urgent suspected cancer pathway?
- What can I do if my patient has raised platelets?

Watch our free webinar here to learn more. Meet the Specialists' series, we will be speaking to Professor Gordon Jayson, Profes-sor of Medical Oncology at The Christie NHS Foundation Trust.

## NICE backs Lilly's Emgality for migraine, adding pressure on Novartis

By Phil Taylor-Pharmaphorum

UK cost-effectiveness agency NICE has said that Eli Lilly's Emgality can be made available through the NHS for migraine prevention, the second drug in the CGRP inhibitor class to achieve that milestone. The decision means that with two CGRP antibodies now cleared for migraine prevention, the first drug in the class to be approved in Europe-Novartis' Aimovig (erenumab) – has fallen further behind its rivals in getting access to the UK market. NICE has backed Emgality (galcanezumab) as a once-monthly injection to prevent migraine attacks in people with episodic or chronic migraine who suffer at least four days with a migraine headache per month, and who have tried at least three prior preventative medicines.

That puts Emgality ahead of Teva's Ajovy (fremanezumab), which picked up a positive opinion from NICE earlier this year but is only recommended for use in chronic migraine sufferers who have 15 or more headache days a month for more than three months, with at least eight of those having features of migraine. It also puts Lilly's drug ahead of Aimovig, which has been rejected twice by NICE although the agency has agreed to take another look at the application after an appeals panel ruled that its technology appraisal committee had failed to consider all of the evidence about the cost-effectiveness for the drug. NICE said Ajovy was an option for around 10,000 people in the UK in guidance issued in June, but Lilly says many more patients are eligible for its drug – around 144,000 people with episodic migraine and 59,000 people with chronic migraine.

The decision is based on trials comparing Emgality with placebo which showed that the antibody halved the number of monthly migraine headache days for up to 40% of adults with migraine who had previously tried three or more prior medicines, such as Allergan's Botox (botulinum toxin type A) or topiramate. Gemma Jolly of medical charity the Migraine Trust said NICE's recommendation is "wonderful news for people living with this very painful and debilitating neurological condition [as] both chronic and episodic migraine patients across England and Wales will be able to access an effective drug on the NHS."

The CGRP inhibitors have performed well in clinical trials, but so far commercial success has been limited, despite blockbuster sales predictions ahead of their approval.

First-to-market Aimovig generated sales of $108 million in the first nine months of 2020 for Novartis, which records ex-US sales, while Amgen booked $274 million from the drug in the US in the same period.

Aimovig is said to be the most prescribed anti-CGRP drug worldwide with more than 480,000 patients prescribed the drug worldwide. In the same period, Lilly reported sales of $253 million for Emgality, and Teva made $98 million from Ajovy.

Novartis is hoping for a bounce to Aimovig sales from the HER-MES trial reported earlier this month, which showed it was more effective than topiramate – a go-to oral therapy for people with chronic migraine – in a head-to-head trial. There's more competition jostling for position however, following the approval of Lundbeck's Vyepti (eptinezumab), an intravenous drug that only needs to be administered four times a year.

Lilly has a real opportunity to build momentum behind Emgality in England and Wales, but will have to wait until next year before it hears from NICE's counterpart in Scotland,the Scottish Medicines Consortium (SMC). Aimovig was cleared for use by NHS Scotland last year, with Ajovy given a green light in January 2020. Click here for the source article.

### A FRESH APPROACH TO GENERAL PRACTICE

By Royal College of General Practitioners

The RCGP has announced plans for a two-day online conference in February: A fresh approach to general practice.

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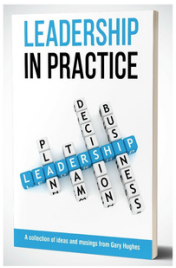


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# Subject Access Requests

By NHS England

The General Data Protection Regulation (GDPR), which was implemented in the UK through the Data Protection Act 2018, gives individuals the right of access to their personal data from any health and care organisation that holds records on them.

This right is commonly referred to as 'subject access'. This guidance is intended to help you understand what a Subject Access Request (SAR) is. During the COVID-19 period the Information Commissioner's Office (ICO) recognises that organisations may not be able to respond within the usual timeframes.

**Guidance for healthcare workers:** As a health and care professional, or someone supporting the health and care of patients and service users, you need to know that patients have the right to access their records and who in your organisations is responsible for responding to these subject access requests. Your organisation has one month to action and respond to a SAR. So you need to forward the request to the appropriate person or team as quickly as possible. If you are involved in responding to a request, see the section for information governance (IG) professionals for further information.

**Guidance for IG professionals-Key points.** These key points will support you in meeting the requirements of the GDPR:

1. Review your SAR procedures.
2. Be aware of reduced timescales to action a SAR. You now have one month from the receipt of the request. For example, a request received on 3 September must have been responded to by 3 October.
3. Enable your patients and service users to access their records online, rather than providing photocopies.
4. If you need to communicate your refusal to a SAR to the patient and service user, you should provide information about their rights to complain to the Information Commissioner's Office (ICO).

Failure to comply with a legitimate SAR results in a risk of breaching the GDPR and a potential sanction by the ICO. The maximum fine that can be issued by the ICO is 4% of global turnover or 20 million euros (or equivalent in sterling).

To read the full guidance please visit the source article here

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## Furlough extension: what we know now

Advice by Owen Clark, Associate Director at Peninsula

The government has now published its official guidance for the Coronavirus Job Retention Scheme, which has been extended until 31 March 2021.

The long-awaited government guidance confirms many of the details surrounding the extended furlough scheme for employers. Overall, it outlines that despite the increase in flexibility that the extended scheme provides when compared to its original incarnation in March, such as permitting flexible furlough from the start. The government have also placed further restrictions on its usage that we haven't seen before. Likely to keep its ongoing cost down.

A crucial point is the situation regarding making claims for furloughed staff who are serving their notice period. Previously there were no restrictions on this and staff could be made redundant even if they were currently on furlough.

Now, it seems that the government are going to be a bit stricter in this regard, suggesting that from December they may prohibit claims for those who are serving notice periods. While this has yet to be confirmed, it would be consistent with previous government plans for the furlough scheme's planned replacement, the Job Support Scheme before it was indefinitely postponed; claims were not to be permitted for those serving a notice period.

There is also a significant change confirmed for staff who wish to return from maternity leave early to be instead placed on the Job Retention Scheme and therefore receive more money. They now need to provide at least eight weeks' notice of their intention to do this, and their employer cannot place them on furlough until these eight weeks are up. This does provide less freedom for staff in this position, and employers will need to make sure that all employees seeking to return off maternity leave early are aware of this. Depending on their situation, it may be more advisable for them to remain on the leave as planned.

On a more positive note, the government have clarified that rules on taking annual leave while furloughed are to remain the same; those who do take it must be paid in full for this time. They have also provided further guidance for furloughed staff who fall ill, suggesting that, generally, it will be down to employers if they keep them furloughed or class them as on sick leave and therefore start paying them SSP if they qualify. However, future amendments to the guidance will hopefully clarify this further and employers should approach this situation with caution for now.


Another central point to consider is guidance on whether staff that has transferred over to a business under TUPE can be furloughed. As before, it seems that this will depend on when the transfer took place, critical dates for which being specified in the guidance. Going forward, it is essential that employers familiarise themselves with this guidance as much as possible and regularly check it for updates. It should be remembered that the furlough scheme has seen numerous amendments since it was originally implemented, a trend that does seem likely to continue over the next few months.

For expert advice and guidance on furlough and redundancies, call Owen Clark, Associate Director at employment law consultancy, Peninsula, today on 07966112 073

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**About Peninsula**

Peninsula is one of the UK's premier companies, started in 1983. The company offers HR, employment law and health & safety support services to small and fast-growing businesses across the country, as well as tax and payroll advice, employee assistance programmes, and HR and health & safety training. Since its beginnings in Salford, Peninsula has now expanded into the furthest corners of the globe, operating in Ireland, Australia, New Zealand and Canada.

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Over the last 20 years Nigel has won 62 rurality battles, fought over 100 predatory pharmacy applications and obtained 22 pharmacy licences for Dispex members. He is an acknowledged expert on the Pharmaceutical Service Regulations as applicable to pharmacy and dispensary doctor contractors. If you have a problem he should be your first port of call.

If you have a Dispensary query or issue that you feel requires expertise guidance, then please, contact Nigel directly or through the Dispex office on **01604 859000.** NVM Holdings [Northants] **office@nvmholdings.com**

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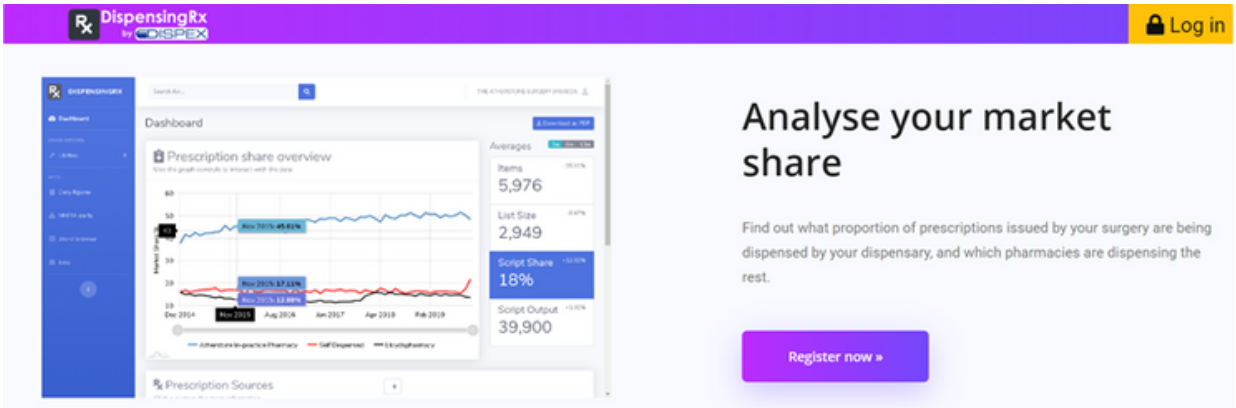


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Why are Practice Managers not valued?
*By Ben Gowland-Practice Index*

## Why are Practice Managers not valued?

The golden hello scheme was agreed as part of the 2020/21 GP contract deal and opened to applications on 1 July this year after being delayed by the coronavirus pandemic.

Golden hello payments are available to people taking up partnership roles in general practice for the first time after 1 April 2020, and can be claimed not only by GPs who become partners, but also nurses (including ANPs), pharmacists, pharmacy technicians, physiotherapists, paramedics, midwives, dietitians, podiatrists, occupational therapists, mental health practitioners.

A notable exception to the list is practice managers. Odd, of course, because there has been an increasing number of practice managers made partners of GP practices in recent time (certainly more than most of the roles listed above!), yet they are not part of the list.

NHS England has stated on a number of occasions that they are hoping to expand the offer to include practice managers, but it is clear that there is opposition to this that is proving difficult to overcome.

This then raises the question of who is arguing the case for practice managers on a national level? Indeed, is anyone?

In technical terms, practice managers are represented as part of practices by their local LMC. The LMCs are then represented nationally by the GPC. But they are representing practices as a whole, and practice managers question whether the voice of practice managers really gets heard at that level. Indeed, there are reports of resistance within the GPC to the idea of a practice manager committee operating within it.

A recent Practice Index poll found that an astonishing 55% of practice managers are considering leaving the profession in the next 12 months. Morale across the profession, as our panel recently discussed, is at an all-time low.

PRACTICE INDEX
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The two issues are clearly linked. General practice as a whole is under huge pressure, and much of that pressure falls directly on the shoulders of the practice managers. At the same time, there is nobody fighting the corner for practice managers or acting on their behalf. They feel abandoned and alone and, unsurprisingly, many are seriously considering leaving.

The time is surely now for this issue to be addressed. Practice managers need some sort of voice, some national representation. Without it, it won't just be practice managers who suffer, but the whole of general practice.

Practices simply can't afford to lose their practice managers.

But the reality is that if this change is to happen, practice managers themselves will need to make it happen. Nearly all practice managers have come together on the Practice Index site. It is time to build on this unity and work together to establish a national body, whether this is a new one or part of an existing organisation.

It can be done. It will inevitably require a small number of individuals to put their heads above the parapet and take this on. More importantly, it will need everyone else to rally behind them. It may well require the profession to introduce its own accreditation. But it will be worth it because it will create a legitimacy and a national voice that to date has been sadly lacking.

Let's hope we reach a point soon where practice managers start to be valued and recognised for the work they do, and stop being treated as second class to the clinical roles working in general practice.

Click here to view the source article

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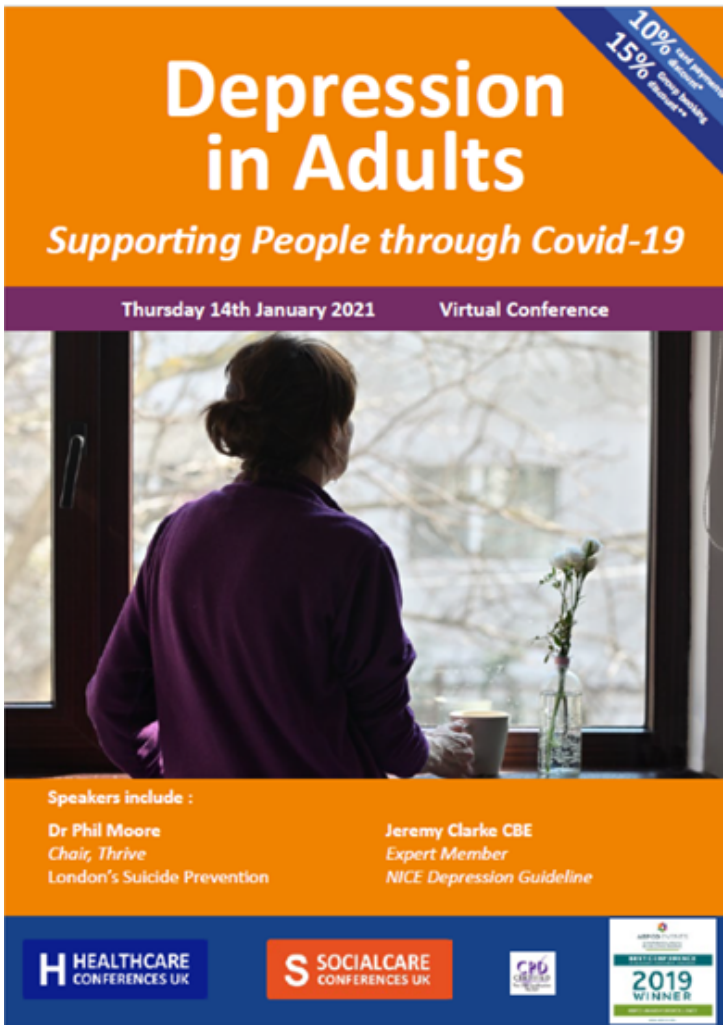



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# Future of the 'safety features' measures under FMD in Great Britain and Northern Ireland- by UK FMD 16/11/2020

### Update from UK FMD Working Group for Community Pharmacy

Now that the UK has left the EU and the Transition Period ends on 31st December 2020, some regulatory requirements will no longer apply. However, certain EU legislation will continue to have effect in Northern Ireland under the Northern Ireland Protocol.

## Pharmacies in Great Britain

The 'safety features' elements of the EU Falsified Medicines Directive (FMD, 2011/62/EU) and Delegated Regulation (2-016/161) cease to have effect in Great Britain from 31st December 2020. This means that pharmacies (**and other end users such as wholesalers, hospitals and others handling or supplying medicines**) will no longer be required by law to verify and decommission unique identifiers on prescription medicine packs.

**.** End users in Great Britain will be disconnected automatically from the UK National Medicines Verification System (UKMVS) run by SecurMed UK. This means that it will no longer be possible to verify and authenticate packs from 1st January 2021. Pharmacy operators and system suppliers need to check that any integrated pharmacy systems with FMD functions are no longer actively connecting to or seeking a response from the UKMVS after the end of 2020. Stand-alone FMD systems can simply be turned off.

**.** Integrated pharmacy systems can still use batch details, expiry dates or product details (GTINs) from packs' 2D barcodes while these packs are still in circulation. However, pack serial numbers no longer have any function. These packs remain valid and can be dispensed for as long as they are still in date.

**.** SecurMed UK will continue to provide end user registration and necessary support up to 31st December 2020 for end users in Great Britain.

Pharmacies in Northern Ireland Under the terms of the Northern Ireland Protocol, part of the UK's Withdrawal Agreement with the EU, FMD will still apply in Northern Ireland, for at least four years (until the NI Protocol is due to be reviewed).

**.** End users in Northern Ireland will remain connected to the UKMVS. They need to continue to verify and decommission any packs with the FMD safety features (unique identifiers and anti-tamper devices) in line with the requirements of relevant EU and UK medicines legislation.

**.** SecurMed UK will continue to provide end user registration and necessary support to enable Northern Ireland end users to decommission packs with FMD identifier features in to 2021 and beyond.

The UK participated in discussions with the EU to agree a phased implementation of medicines regulations in Northern Ireland, under the NI Protocol, by 1 Jan 2022. The UK published a statement, agreed with the EU, on 5 Nov 2020 confirming a 12-month phased implementation of the Falsified Medicines Directive and regulatory importation requirements for medicines moving from GB to NI. Work is continuing with the EU to agree operational specifics. Please check the latest guidance for industry, the first version of which was due to be published soon after the release of this document https://www.gov.uk/government/news/irelandnorthern-ireland-specialised-committee-05-november-2020

## Future national falsified medicines system

The Medicines and Medical Devices Bill (progressing through Parliament) would enable the Government to make regulations aimed at preventing falsified medicines from entering the medicine supply chain. This could include establishing a national system based on the unique identification of individual packs that enables medicines to be authenticated and identified if tampered with.

The Government will have to consult with industry stakeholders, including pharmacy organisations, before introducing any new Regulations. No timetable has been set by the Government for consultation.

**Actions to take-Great Britain:**
End users should check that any integrated pharmacy systems are no longer actively connecting to or seeking a response from UKMVS from the end of 2020. Turn off or disconnect any stand-alone FMD systems after 31st December.

Northern Ireland: End users should ensure they are registered with SecurMed UK (www.securmed.org.uk), if they have not already done so. Pharmacy teams should continue to verify and decommission FMD-compliant packs of prescription medicines. Refresher training should be carried out if needed. Click here for the source article

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* Figures available upon request