Community Pharmacy Surrey & Sussex
On behalf of East Sussex, West Sussex and Surrey LPCs

Consultation Response

Department of Health and Social Care
Consultation on Community Pharmacy Reimbursement Reforms

September 2019

For enquiries regarding this response, please contact:

James Wood FRPharmS
Chief Executive
Community Pharmacy Surrey & Sussex
jameswood@communitypharmacyss.co.uk

About Community Pharmacy Surrey & Sussex

Community Pharmacy Surrey & Sussex is the local voice for all community pharmacies on behalf of East Sussex, West Sussex and Surrey Local Pharmaceutical Committees (LPCs).

We represent over 530 pharmacies, on all matters relating to the NHS and public health work undertaken by community pharmacy. This includes single handed independent pharmacies through to medium and large pharmacy businesses. Pharmacies in our area, between them, employ thousands of local people and are at the heart of communities.

Community Pharmacy Surrey and Sussex negotiates and discusses local pharmacy services with commissioners and is available to give advice to community pharmacy contractors and others wanting to know more about local pharmacy. We are committed to helping to develop and support community pharmacy teams, to deliver high quality health services.

Working closely with the local NHS, including NHS England Area Teams, CCGs and local government, we are responsible for advancing the enhanced role of community pharmacy to ensure it plays an active part in promoting health and wellbeing across Surrey and Sussex. Our vision is to enhance the role of community pharmacy and to ensure the sector has an active role in promoting health and wellbeing in Surrey and Sussex.

Local Pharmaceutical Committee (LPC) are local representative committee of pharmacy contractors in the area covered by the LPC that has been approved by NHS England under the NHS Act 2006, as the body representing the owners of the community pharmacies in the Surrey Health and Wellbeing Board area.

Regulations under the NHS Act require NHS England to consult LPCs on matters such as market entry and local enhanced services. The LPC negotiates and discusses locally commissioned pharmacy services with other commissioners and is available to give advice to community pharmacy contractors and others wanting to know more about local community pharmacy.

The LPC constitution sets out the role and duties of the LPC that include:

- representing their contractors in local and national consultations relevant to pharmacy contractors; making representations to NHS England, Health and Wellbeing Boards and PSNC.

- providing support, resources and guidance to pharmacy contractors, such as advice on contract compliance and monitoring, market entry and other locally commissioned services.

- promotion and development of local pharmacy through local public affairs and lobbying to create an environment for community pharmacy to flourish.

Further information is available on our website at http://communitypharmacyss.co.uk/

Consultation Response – Overview

We welcome the opportunity to be able to provide our response to consultation on community pharmacy reimbursement reforms. We are pleased to see the Department of Health & Social Care consulting on these issues as committed in the NHS Long-term Plan, published earlier this year.

One of the biggest areas of concern to community pharmacy contractors is that of accurate, fair and equitable reimbursement. This has been a constant theme of feedback that we receive from local pharmacies over the last few years, with many being concerned about the impact of dispensing at a loss. We hope through these reforms, the Department of Health & Social Care can work with the sector to deliver improved reimbursement arrangements that deliver smoother and fairer distribution of margin for all contractors.

We recognise that issues concerning reimbursement are complex and the impact of any changes will need to be carefully communicated and understood. We also urge this to be drilled down to a local level, recognising the potentially critical impact reforms could have to an individual pharmacy viability, dependent on dispensing mix and local prescribing.

In addition, as a more general point in respect of most of the questions, we encourage any post - consultation implementation to be carefully planned, managed and monitored, in what appears to be a fragile system of many interdependencies. It is particularly important to avoid further volatility in supplies, costs and adverse workload for community pharmacies. Periods of review, working with the sector, through PSNC, appear to be a pre-requisite to ensure post-implementation analysis and refinement if needed.

Our response to the specific questions are set out below.

Consultation Questions

Section 4. Changes to the determination of reimbursement prices of generic medicines in Category A

Question 1. Do you agree with the proposed reform?

We generally agree that the setting of Category A reimbursement prices needs to be revisited, which could include making use of and reference to, data gathered under the Health Service Products (Provision and Disclosure of Information) Regulations 2018.

Question 2. Do you have any comments on the proposed reform?

Given our opening comments, we would urge that to avoid dispensing at a loss, reimbursement for Category A medicines should be based on wholesaler price data. Using manufacturer price data would be an inappropriate mechanism for price setting of Category A products, which are generally of lower volume / usage and have less competition than those in Category M.

Timeliness of the system to adjust prices is equally important and we would urge this to be as short and efficient as possible, to avoid potential increases in the the need for price concessions, increase costs for the NHS and distort margin delivery for contractors.

Section 5. Changes to the distribution of medicine margin added to generic medicines in Category M

Question 1. Do you agree with the proposed reform?

It is well understood within the community pharmacy sector that the current mechanism for distributing margin within Category M has been problematic. There have been unintended consequences which have caused inequality of margin distribution amongst contractors and therefore we welcome this proposal and encourage discussion with PSNC.

Question 2. Do you have any comments on the proposed reform?

We cautiously welcome what this proposal seeks to deal with. The following issues must be considered as part of any changes to price setting and margin distribution mechanisms:

- Reduction of margin on certain Category M products which increase risk of inequality in distribution of margin amongst contractors
- Reduction of margin on certain Category M products should not result in dispensing at a financial loss

The LPCs are concerned that at a local level how the principal of “winners and losers” at individual pharmacy level shakes out, especially with any reduction of margin on a section of Category M products. Further to our opening comments on page 3, changes should not result in dispensing at a loss. We would like to see mitigations to avoid this discussed and agreed as apart of these proposals.

Section 6. Changes to the determination of reimbursement prices of medicines in Category C which are prescribed generically but have multiple suppliers

Question 1 and 2 Do you agree with the proposed reform?

We have a number of concerns about the potential consequences of the proposed reforms regarding changes to price setting for Category C medicines and would encourage further work with the sector, via PSNC to explore suitable safeguards in the system, to ensure the protection of patient safety and access, the prevention of dispensing at a loss for contractors, and to reduce the risk of supply issues.

Question 3. Do you have any comments on the proposed reform?

- If a prescription does not specify a brand, pharmacy staff may be compelled to dispense products to avoid dispensing at a loss. Unless prescribers change their prescribing policies, or prescribing systems are developed to default prescribing of certain products by brand name based on MHRA/BNF/ or other professional guidance, this proposal is likely to impact on patient safety, arising from unwanted changes and variation to patient treatment. It potentially undermines relationships between community pharmacy staff and patients

- There could be a significant increase in workload for both pharmacy teams and prescribers, where prescriptions need to be re-issued to allow dispensing of products which are above the new price. We would also be concerned about the impact of such requests in patients receiving medicines and adding friction to local GP and Pharmacist relationships at a time when NHS England is encouraging greater collaboration around direct patient care.

- Potential changes to Category C would impact of stock holding in pharmacies and sufficient lead time in terms of implementation should be given to avoid waste and cost of redundant branded product stock.

Section 7. Inclusion of drugs (other than licensed and unlicensed medicines) with a reimbursement price in Part VIII

Question 1 and 2 Do you agree with the proposed reform?

We recognise the need to re-examine this section and would steer towards option 1. However, there are several issues to consider, further described below, not least that only included in the Drug Tariff are non-medicinal products where no medicinal equivalent (licensed or unlicensed) are available.

Question 3. Do you have any comments on the proposed reform?

We would be concerned about the impact of these proposals putting pharmacists in difficult professional decision-making situations. Potentially being compromised with complying with important guidance set out by MHRA and others, such as the General Pharmaceutical Council in relation to supply considerations of unlicensed medicines.

The tariff should be made sufficiently clear to assist both dispensers and prescribers, that the requested product is non-medicinal and may fall outside of the existing requirements under Clause 1 of the Drug Tariff (which indicates that drugs in the Drug Tariff should not be of a grade or quality lower than that ordinarily used for medicinal products). If a licensed or unlicensed medicinal product becomes available in the market, the tariff should be updated and equivalent non-medicinal product must be removed.

Section 8. Changes to the determination of reimbursement prices for non-part VIIIA drugs

Question 1. Do you agree with the proposed reform?

No, we have a number of concerns about this part of the consultation and the impact the proposals may have as proposed on community pharmacies.

Question 2. Do you have any comments on the proposed reform?

Reimbursement for products not in Part VIII of the Drug Tariff is currently based on contractors' endorsements, this ensures contractors are reimbursed appropriately. We are therefore concerned about the proposals about indicative reimbursement prices and call for closer real time (within month) visibility of this information.

It is essential that reimbursement prices are reflective of the market in terms of selling prices and availability, and that contractors are provided maximum visibility of reimbursement before dispensing. This is epically important given that some of these products are specialist, low volume and subject to price variation.

Section 9. Changes to the arrangements for reimbursing and procuring unlicensed medicines ('specials')

Question 1. Do you agree that DHSC should include tablets and capsules with a reimbursement price in the Part VIII of the Drug Tariff?

Yes, subject to our response below being considered.

Question 2. Do you have any comments on the proposal to include tablets and capsules with a reimbursement price in the Part VIII of the Drug Tariff?

- If these proposals are introduced, rules around Broken Bulk arrangements should be re-examined, given the oral solid-dose unlicensed medicines are unlikely to be manufactured in custom sizes. As pharmacists are reimbursed for the exact quantity ordered on a prescription (with exception of any products classed as special containers), any residual stock left over from the original pack size used for dispensing is unlikely to be used again and will need to be discarded.
- A move away from reimbursement based on endorsement for non-Part VIIIB unlicensed medicines, would carefully need to consider timely adjustments to avoid issues any issues in payment accuracy,

Question 3. Which is your preferred option for the procurement and reimbursement of specials that cannot be listed with a reimbursement price in Part VIII of the Drug Tariff?

We do not support the proposed options due to the restrictions and impact they may have on community pharmacy contractors and their teams. We urge for alternative options to be scoped.

Question 4. Do you have any comments on the options and/or do you think there are additional options that should be considered?

Our principal concerns relate to the reduction in flexibility to source unlicensed medicinal products, potential delays and increase in administration burden of such third-party systems at procurement, supply and dispensing. We are already aware of the full bandwidth and heavy workload faced by community pharmacy contractors and their teams in the delivery of the Community Pharmacy Contractual Framework.

Section 10. Changes to the reimbursement of generically prescribed appliances and drugs dispensed as 'specials''

Question 1. Do you agree with the proposed reform?

No, in the current proposed reform.

Question 2. Do you have any comments on the proposed reform?

The proposed changes to the Drug Tariff reimbursement rules for non-medicinal products could inadvertently encourage the supply of a non-medicinal product over medicinal products. Further to our points in section 7, this fundamentally conflicts with important MHRA guidance around supply of unlicensed medicines and we respectfully suggest this needs to be reconsidered.

Section 11. Changes to the deduction scale to reflect different levels of discount for branded and generic medicines

Question 1. Do you agree with the proposed reform?

Yes

Question 2. Do you have any comments on the proposed reform?

We represent just over 530 pharmacies across Surrey & Sussex across 12 NHS Clinical Commissioning Group (CCG) areas. We see significant variation across the CCGs in relation to branded (including branded generic) and generic prescribing via differences in prescribing and medicines management policies. This leads to the distribution of retained margin to be distorted and is problematic for pharmacies in these areas compared with others. We would be happy to share further local issues, experiences and impact with the Department.

We therefore welcome a fairer system of remuneration and would like to call out the following sections of the consultation, which describe and recognise the issues. We particularly welcome reform in relation to this area:

> *3.10 Some suppliers and manufacturers of branded medicines, including branded generics, price their products below the Category M reimbursement price. This can have a distorting effect on*

prescribing decisions because the branded version then appears cheaper, which encourages CCGs and prescribers to prescribe the product by brand rather than generically. To take the simplest example of how this might work in practice, when a GP prescribes a medicine, the software that they use will generally inform them of the Drug Tariff reimbursement price of the medicine. It will also generally inform them of branded versions of the medicine that are available and their prices. It may therefore look to the GP that a branded version represents good value to the NHS because its list price is below the Drug Tariff reimbursement price.

3.11 In reality, however, the branded medicine may well be more expensive to the NHS because it does not contribute (or contributes very little) to the £800 million medicine margin under the CPCF. This in turn leads to a shortfall in medicine margin that will need to be factored elsewhere into reimbursement prices. This also leads to an unequal distribution of medicine margin amongst pharmacy contractors, and it also means that the NHS overall will lose money because some reimbursement prices will have to be set higher than it would have done - to the ultimate detriment of CCGs as a cohort.

3.12 In addition, where CCGs recommend prescribing the branded product because they see it as cheaper to them, pharmacy contractors in the CCGs' catchment area do not have equitable access to medicine margin as they do not retain medicine margin on brands. This also means that not all CCGs contribute equally to the £800 million medicine margin under the CPCF. So, an individual CCG may benefit from the amount apportioned to it in relation to a particular transaction, but CCGs as a cohort and the NHS overall will lose out

In splitting the discount scale, it is likely that there will be contractors who experience higher or lower levels of discount deduction, dependent on whether their dispensing mix is above or below the national average regarding brand/generic split. We see significant variation locally between CCG areas and therefore are generally supportive for action here to support a fairer system across all pharmacy contractors. This would include those with a higher proportion of brand prescriptions, having a lower level of discount deduction than a pharmacy with a higher proportion of generic prescriptions.

Other Comments

We hope that there is a wider opportunity, building on these reforms to consider again proposals for Generic Substitution mechanisms through community pharmacy. This could support principles around medicines optimisation, manage primary care workload, release time for front line patient care and to help reduce financial burden on the NHS.