

The community pharmacy

A guide for general practitioners and practice staff

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Section 1. About this guide

This guide aims to support general practitioners (GPs) and community pharmacists in developing more effective working relationships and in turn, improve primary care services for patients. It covers key areas such as funding arrangements for pharmacies, the impact of prescribing policies and the range of clinical and administrative functions that community pharmacies currently provide.

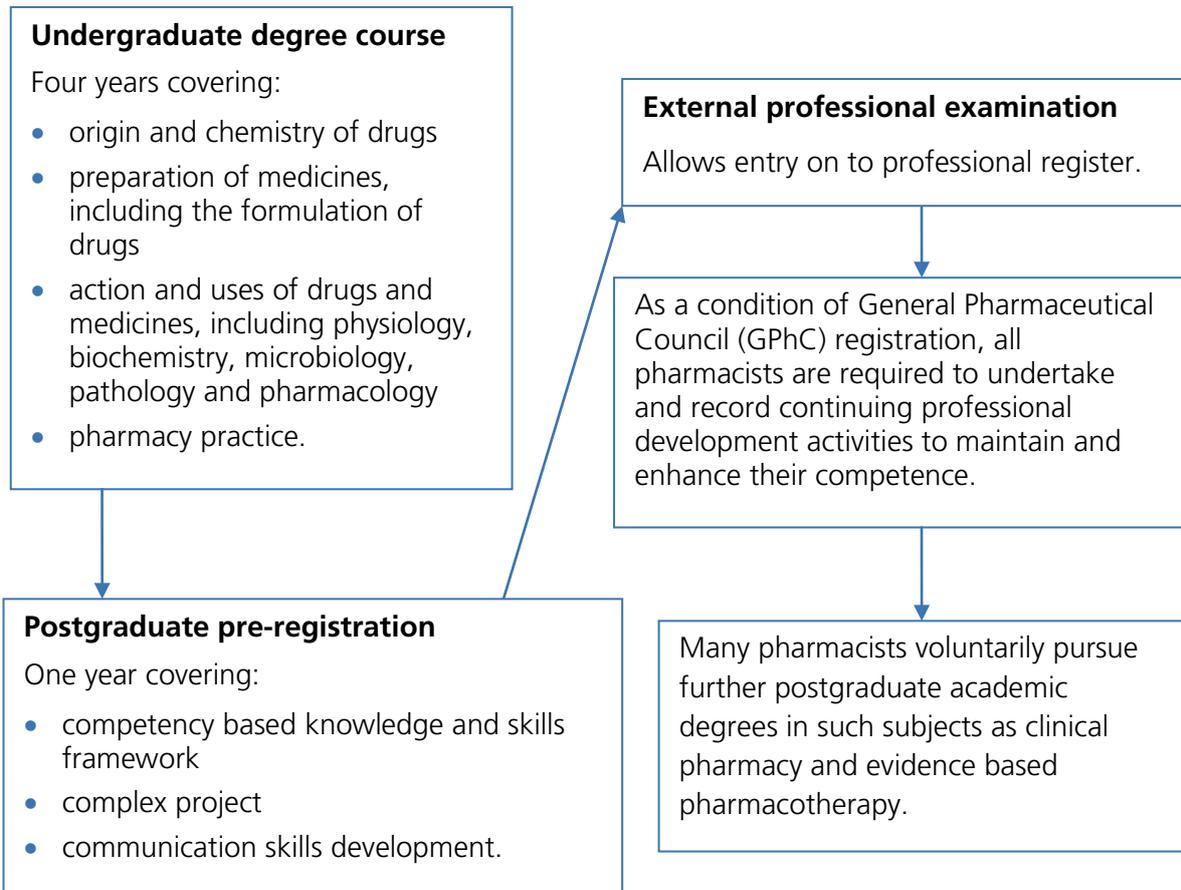
This guide has been developed jointly by the NHS Employers organisation, the British Medical Association's General Practitioners Committee (GPC) and the Pharmaceutical Services Negotiating Committee (PSNC). A similar guide has been produced for pharmacists to give them an insight into the working life of a GP and their practice, and different contracting routes for GPs, including the General Medical Services (GMS) contract.

These guides aim to support the two professional groups, as well as provide an insight for commissioners as new ways of integrated working in primary care start to take shape.

Section 2. Qualifying as a pharmacist

As with other healthcare professions, the underlying principle for all pharmacy education and training is ensuring safe and effective care for patients. This principle underpins pharmacists' work throughout their undergraduate, postgraduate and continued learning, and subsequent career pathway.

Education and training



Extending skills

A growing number of pharmacists are undertaking [prescribing qualifications](#) to become both supplementary and independent prescribers. Although the majority of pharmacist prescribers use their skills in secondary care, community pharmacists are also demonstrating their value in primary care, for example management of substance misuse.

Some pharmacists have also taken the opportunity to develop skills in specialised areas and gain accreditation as a [pharmacist with a special interest \(PhwSI\)](#).

Section 3. Key national bodies

There are several national organisations that have key functions for community pharmacy. These include the General Pharmaceutical Council, the Royal Pharmaceutical Society and the Pharmaceutical Services Negotiating Committee.

The General Pharmaceutical Council

The General Pharmaceutical Council (GPhC) was formed in September 2010 as an independent body responsible for all aspects of professional regulation. Previously all functions of the professional regulator were incorporated into the work of the Royal Pharmaceutical Society of Great Britain (RPSGB).

The regulatory body sets and monitors the professional standards and principles that all pharmacists must work to, as well as setting the standards for undergraduate education and pharmacy premises. The core professional principles that underpin a pharmacist's work are set out in standards of conduct, ethics and performance that every pharmacist must comply with. Additionally, there are standards for registered pharmacies; continuing professional development; and initial education and training requirements for pharmacists and pharmacy technicians.

The Royal Pharmaceutical Society

The Royal Pharmaceutical Society (RPS), formerly the Royal Pharmaceutical Society of Great Britain, transferred its regulatory functions to the GPhC in September 2010, and now acts solely as the professional leadership body. It offers support and advice to pharmacists to ensure they are up to date with current practices, as well as developing guidance documents to support high-quality and safe pharmacy practice.

The Pharmaceutical Services Negotiating Committee

The Pharmaceutical Services Negotiating Committee (PSNC) is the representative body for community pharmacies in England that provide NHS services. It negotiates the national NHS contractual terms on behalf of pharmacy contractors, and provides support to the network of local pharmaceutical committees (LPCs).

Section 4. The NHS Community Pharmacy Contractual Framework (CPCF)

A new contractual framework for community pharmacies was introduced in April 2005. The table below lists the types of services included in the contractual framework.

<p>Essential services</p>	<p>Provided by all contractors.</p> <p>This consists of the following core services:</p> <ul style="list-style-type: none"> • dispensing • repeat dispensing • disposal of unwanted medicines • promotion of healthy lifestyles (public health) • signposting • support for self-care. <p>Services are provided under a clinical governance framework that includes clinical audit and information governance requirements.</p>
<p>Advanced services</p>	<p>Can be provided by all contractors once accreditation requirements have been met.</p> <p>Currently there are four advanced services:</p> <ol style="list-style-type: none"> 1. Medicines Use Review (MUR) and Prescription Intervention (PI) Service. <p>Regular MURs can be prompted proactively by identification of a certain group of patients (for example those in the national target groups) that subsequently lead to an invitation for an MUR. A prescription intervention MUR is more reactive, in the sense that it is the response to a significant adherence problem with a person's medication that subsequently leads to an MUR being conducted. The issue or issues that prompt the pharmacist to offer an MUR in this circumstance are likely to be highlighted as part of the dispensing process. Commonly the issues will highlight the need for the patient to develop their understanding of their medicines in order to improve their own use of the medicines.</p> <p>The same consultation occurs for MURs and PI MURs, for example establishing the patient's actual use, understanding and experience of taking all their medicines; identifying, discussing and assisting in the resolution of poor or ineffective use of drugs by the patient; identifying side-effects and drug interactions that may affect the patient's</p>

compliance with instructions given to him/her; and improving the clinical and cost effectiveness of drugs prescribed to patients, thereby reducing drug wastage.

In October 2011 a new requirement was introduced that at least 50 per cent of all MURs undertaken by each pharmacy must be for patients who fall within one or more of the national target groups. These groups are:

- patients taking a high-risk medicine (on a [nationally agreed list](#))
- patients with respiratory disease
- patients recently discharged from hospital who have had changes made to their medicines whilst in hospital.

MURs can still be carried out on patients who are not in one of the target groups if, in the pharmacist's professional opinion, the patient will benefit from the service. For more information about this service see [Guidance on the Medicines Use Review service](#).

2. [Stoma Appliance Customisation service](#)

3. [Appliance Use Review service](#).

The above two services were introduced in April 2010 following Directions issued by the Secretary of State for Health in December 2009. These services can be provided by both pharmacies and dispensing appliance contractors.

4. New Medicine Service (NMS)

The NMS was introduced in October 2011 and is designed to support patients who have been newly prescribed a medicine for a long-term condition. Four conditions are included in the service: chronic obstructive pulmonary disease (COPD)/asthma, type 2 diabetes, hypertension and antiplatelet/anticoagulant therapy. The service is split into three stages, outlined below.

- Patient engagement: patients may be recruited to the service by prescriber referral or opportunistically by the community pharmacy. The pharmacy will dispense the prescription and provide initial advice as normal.
- The intervention stage will usually take place 7 - 14 days after patient engagement, at a time and using a method agreed with the patient. The pharmacist will assess the patient's adherence, identify problems and determine the need for further information and support.
- Follow up usually occurs 14 - 21 days after the intervention to discuss how the patient is managing with their medication.

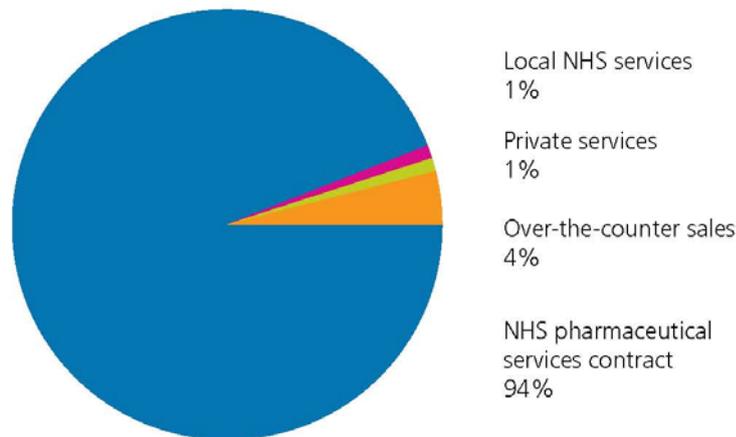
	For more information about this service see the New Medicine Service guidance .
Enhanced Services	<p>Local services commissioned by NHS England</p> <p>Until 31 March 2013, all locally commissioned pharmaceutical services were known as enhanced services, and were commissioned by primary care trusts (PCTs). Since 1 April 2013, only NHS England can commission enhanced services from pharmacies, in order to meet the needs set out in the Pharmaceutical Needs Assessment (PNA). This could include services such as:</p> <ul style="list-style-type: none"> • minor ailments service • anticoagulation monitoring • palliative care service. <p>Any pharmacy enhanced services originally commissioned by PCTs (with the exception of those with a public health element) should have transferred to the relevant area team of NHS England on 1 April 2013. Locally commissioned public health services will only be defined as enhanced services if they are commissioned by NHS England on behalf of Local Authorities or Public Health England (PHE).</p>
Locally commissioned services	<p>Services commissioned locally</p> <p>Local public health services are commissioned by local authorities or PHE. These might include:</p> <ul style="list-style-type: none"> • smoking cessation • emergency hormonal contraception (EHC) • supervised administration service. <p>Clinical Commissioning Groups (CCGs) may also commission local services from community pharmacy to meet the needs of the local area.</p>

Changes to the Community Pharmacy Contractual Framework (such as the 2011 introduction of the NMS, targeted MURs and changes to clinical governance arrangements) are negotiated by the Pharmaceutical Services Negotiating Committee (PSNC) and NHS Employers (on behalf of NHS England). This includes negotiating the funding structures for new advanced services as well as leading implementation of new services and changes to existing services. NHS Employers and PSNC also publish guidance documents for several advanced and locally commissioned services.

Further information on the contractual services can be found on the [PSNC website](#) and on the [PSNC services database](#).

Section 5. Funding for community pharmacies

Individual pharmacy income varies according to the mix of over-the-counter (OTC) business and the volume of prescriptions dispensed. The average pharmacy (excluding very large high street pharmacies and supermarket pharmacies) earns 90–95 per cent of its income from NHS services. The diagram below shows the typical annual income for an average community pharmacy.



Funding for the national pharmacy contract

Details of community pharmacy remuneration for essential and advanced services are set out in the Drug Tariff. The total nationally agreed funding is distributed through a combination of fees, allowances and purchasing margin. Further information on purchase margin is provided on page 11.

The total funding available for all pharmacies, including essential and advanced services provided is negotiated between the Department of Health, NHS England and PSNC. There are allowances such as the Establishment Payment, which is a set amount payable to qualifying pharmacies, and the remainder of the agreed total is distributed through agreed purchase margin and fees per prescription. Variation of prescription volume or margin achieved on purchasing drugs is closely monitored and adjustments made in drug reimbursement and in dispensing fees to ensure delivery of the agreed total.

Contract remuneration	Services covered
Professional fee	Pharmacy contractors receive a professional fee for every prescription item they dispense.
Additional fees	Pharmacy contractors may claim a range of additional fees, which are set out in part IIIA of the Drug Tariff, including fees for extemporaneously dispensing (these are items manufactured or mixed together in the pharmacy), measuring and fitting hosiery and trusses, and dispensing controlled drugs.
Establishment payments	Contractors who exceed a specified volume threshold receive an establishment payment. This payment is based on the volume of prescription items submitted by the pharmacy contractor and processed for payment by NHS Prescription Services for that month.
Practice payments	<p>All pharmacy contractors are eligible to receive practice payments, which include a contribution for the provision of auxiliary aids for people eligible for support under the Equality Act 2010. Pharmacies are required to meet specified dispensing support (staffing) levels in order to qualify for the full practice payment.</p> <p>As with the establishment payment, the actual amount paid to the pharmacy will depend on the volume of prescriptions they dispense.</p>
Repeat dispensing payment	All pharmacy contractors receive an annual repeat dispensing payment to meet the costs of operating the service.
Electronic transfer of Prescriptions (ETP) payment	Each pharmacy that has been validated as having a compliant Electronic Prescription Service (EPS) system will receive a monthly payment as reimbursement for the spine connectivity (N3) service charge.

Details of funding under the Community Pharmacy Contractual Framework can be found on the [PSNC website](#).

Medicines reimbursement

Medicines reimbursement is the price paid back to the pharmacy for the prescription item that was dispensed. The amount that will be reimbursed to the pharmacy for the majority of items prescribed by GPs on NHS prescriptions is tightly controlled by the Department of Health. The overall national value of the reimbursement includes an agreed margin to incentivise efficient purchasing, which is part of the NHS community pharmacy funding.

The price used to reimburse a pharmacy contractor for the medicine or appliance they dispense depends on whether the prescribed product is a 'branded' or 'generic' medicine.

The different types of medicine reimbursement are outlined below:

1. Medicines prescribed by brand name

Where a medicine has been prescribed by brand name, the reimbursement is based on the manufacturer's list price for the prescribed product. The agreement that controls the prices of branded medicines is known as the Pharmaceutical Price Regulation Scheme (PPRS). Although the prices to the NHS of these branded products can be high, pharmacists often make a loss on dispensing them, because the reimbursement price is lower than the purchase price.

2. Medicines prescribed generically

Part VIII of the Drug Tariff contains the basic NHS reimbursement prices for medicines prescribed generically. It includes most of the commonly prescribed products. Part VIII is further divided into categories A, B, C, E and M. Category M is of greatest interest to prescribers, CCGs and pharmacy contractors, because it includes the majority of generic medicines that are prescribed in primary care.

The reimbursement price of all medicines is then reduced by NHS Prescription Services in accordance with a 'discount scale' that reflects the average levels of discounts pharmacies receive from their wholesalers. The average discount deduction is up to 9 per cent and for some items, particularly branded and 'branded' generic products that are supplied to the pharmacy with little or no discount, this means the items are reimbursed at less than cost price to the pharmacy.

The impact of medicines reimbursement on CCG prescribing budgets

It is essential that prescribers understand the implications of the different reimbursement categories of medicines, as the reimbursement prices of some medicines can significantly affect prescribing costs within a CCG. Special care has to be taken to avoid taking action that may produce a short term local saving, while ultimately costing more for the NHS.

Community pharmacists as well as CCG or commissioning support unit medicines management teams are able to offer advice to GP practices on all aspects of the Drug Tariff, to support the practice to achieve safe and cost effective prescribing policies.

The impact of cost saving prescribing policies

Strategies to reduce the cost of drugs used in primary care, while ensuring safe and effective prescribing policies include generic switching programmes and the introduction of 'branded' generics.

Effective communication between practices and pharmacies is essential to understand the risk of an adverse financial consequence to the pharmacy resulting from the policy, and any potential short-term and long-term gains that the policy may deliver for the practice.

Switching programmes

Switching programmes, whether manual or through computer software systems, can be effective to encourage prescribers to consider using a suitable product as an alternative to expensive formulations or proprietary branded products (where the generic is available and appropriate according to NICE guidance).

However, although some of these programmes may appear to generate impressive savings for the prescribing budget holders, the savings may be difficult to sustain if the switches are not effectively communicated to patients or if other factors affecting the dispensing of these items are not taken into consideration. There have been instances where temporary price reductions have led to switching, and subsequently a shortage of the medicine has occurred, with an increase in procurement costs.

'Branded' generic or branded medicines prescribing policies

Although the vast majority of generic medicines in category M are the most cost effective way of prescribing that medicine, at times manufacturers reduce the price of their branded product to one that is cheaper than the equivalent generic product listed in category M. This is done to promote market share of the branded product.

When responsible for prescribing costs, some PCTs encouraged the prescribing of, and switching patients to, specific branded medicines or 'branded' generics. Such a policy may deliver some cost savings to the primary care drugs bill; however, the savings are often unsustainable by the manufacturer.

In addition, by adopting these policies, pharmacies are required to purchase branded products for which there is little or no discount when the items are purchased by the pharmacy. The discount reduction is still applied when the prescription is priced by NHS Prescription Services, and consequently the items may be reimbursed at less than cost price to the pharmacy. This can impact on the financial viability of the pharmacy and put the provision of pharmaceutical care at some risk. The reduction in prices at a local level may actually cause increased prices for the NHS as a whole, as adjustments are made to ensure full delivery of total agreed pharmacy funding. This adjustment is applied nationally, so the adjustment may not restore viability to seriously affected local pharmacies.

Frequent changes to prescribing could also be detrimental to patient care. Continually changing brands can create confusion for patients and can undermine their confidence in their medicines. There is also evidence that some branded generic products that have been subject to switching have quickly become short in supply, leading to delayed access to the medicines for the patient.

Section 6. Running a community pharmacy

All community pharmacies in the UK are independent contractors to the NHS, being owned by a single pharmacist, partnership of pharmacists or a body corporate.

Although providing NHS pharmaceutical services covers the majority of pharmacy business activity, a number of pharmacies also provide a range of private healthcare services. Examples include travel vaccination clinics, seasonal flu vaccinations for members of the public who are not within the NHS prioritised risk groups and erectile dysfunction treatment.

The role of the pharmacist

The daily life of a community pharmacist is hugely varied, drawing on a wide range of clinical and non-clinical competencies and skills. Every pharmacy is required to operate under the control of a 'responsible pharmacist'. The responsible pharmacist (who can only be responsible for one pharmacy) must be satisfied that the operation of the pharmacy will be safe, taking into account the standard operating procedures, staffing levels on the day and any other relevant circumstances.

Daily tasks undertaken by community pharmacists include:

- clinical scrutiny of prescriptions
- oversight of safe dispensing processes
- providing patients with advice about medicines and treatments
- providing the advanced services as detailed above
- provision of public health information to patients and customers and promotion of wellness
- signposting people to other services, self-care organisations or information resources
- assessment and treatment for minor ailments
- professional oversight of the sales of OTC medicines
- liaison with other healthcare professionals
- clinical review services for specific patient groups in GP practices, for example asthma, diabetes, hypertension
- medicines management support for practices, for example supporting practice formulary and clinical guideline implementation, repeat prescription management

- locally commissioned and enhanced services such as supply of Prescription Only Medicines (POMs) under Patient Group Directions (PGDs), screening services, public health interventions and treatments
- involvement with local NHS liaison groups, service development working groups and pharmacy organisations for example the LPC.

Pharmacy support staff

Pharmacists have supported staff to train and develop. This is to ensure that the extended role of the pharmacist can be achieved by having a team who are competent to support and deliver a safe and effective pharmaceutical service.

Position	Role
Medicines counter assistant (MCA)	<p>Medicines counter assistants are generally the first point of contact for patients. They provide a wide range of functions to support the delivery of pharmacy services and the retail functions of the pharmacy. They undertake the prescription reception process, including supporting patients to complete the declaration on NHS prescriptions. Medicines counter assistants also provide advice on the treatment of self-limiting illness and basic healthy lifestyle support, working to a protocol and under the supervision of the pharmacist. Some medicines counter assistants will provide aspects of locally commissioned or enhanced services, such as NHS Health Checks, following appropriate training and accreditation.</p> <p>It is a professional requirement of the GPhC that any assistant who is given delegated authority to sell medicines under a protocol should have undertaken, or be undertaking, an accredited course relevant to their duties. Courses should cover the knowledge and understanding associated with unit 4 (assist in the sale of medicines and products); unit 5 (receive prescriptions from individuals); and unit 15 (assist in the issuing of prescribed items) of the Pharmacy Service Skills Scottish/National Vocational Qualification (S/NVQ) level 2.</p>
Dispenser/dispensing assistant	<p>Dispensers support the pharmacist in dispensing prescriptions and the management of dispensary stock. They will also fulfill the roles of a medicines counter assistant when required.</p> <p>It is a professional requirement of the GPhC that dispensing assistants are competent in the areas they are working on to a minimum standard equivalent to the Pharmacy Services Skills S/NVQ level 2 qualification, or are undertaking training towards this.</p>

Pharmacy technician	<p>Pharmacy technicians support the pharmacist in dispensing prescriptions and managing the dispensary. Like dispensers and medicines counter assistants, they also provide aspects of NHS commissioned services following appropriate training and accreditation.</p> <p>Pharmacy technician training consists of two years consecutive work-based experience under the direction of a pharmacist to whom the trainee is directly accountable for not less than 14 hours per week. To qualify as a pharmacy technician, trainees also need to complete both a GPhC-approved competency-based qualification and a knowledge-based qualification.</p> <p>The statutory registration of pharmacy technicians across Great Britain became mandatory from 1 July 2011.</p>
Accredited checking technician	<p>Accredited checking technicians are pharmacy support staff that have undertaken additional training to allow them to do an accuracy check of dispensed medicines. The pharmacist will do a clinical check of the prescription during the dispensing process. But working with an accredited checking technician means the pharmacist does not need to undertake the final accuracy check of the dispensed medicines in most circumstances.</p> <p>An increasing number of pharmacy contractors are supporting members of their dispensing team to qualify as accredited checking technicians. This is to improve the efficiency of the dispensing process and to free-up pharmacist time to allow them to deliver other services.</p>

Section 7. Community pharmacies investing in the future

As with all independent sector providers in the NHS, community pharmacy has its own opportunities and risks. Many of the opportunities that are already being realised in some pharmacies have resulted from forward thinking pharmacists who have extended their skills, invested in improving the standard of their premises, and developed strong and effective working relationships with commissioners and other local health care providers such as GPs and nurses.

In recent years the direction of travel for community pharmacy has focused on the transition from a business model that relies predominantly on dispensing services, to one that is more heavily reliant on providing clinical services. Examples of opportunities highlighted include the introduction of MURs (including targeted MURs) and the NMS, the Healthy Living Pharmacy (HLP) initiative, the offer of NHS treatments for many minor ailments, and the introduction of screening services.

Many pharmacy contractors have invested significantly to meet the challenges of increasing clinical service provision. The updated clinical governance requirements, introduced in October 2011, ensure robust clinical, corporate and information governance arrangements in pharmacies.

Investments in clinical competencies, pharmacy premises, staff training and qualifications, together with an enhanced IT infrastructure, now provide a firm foundation on which community pharmacy can grow.

Section 8. Frequently asked questions

Why do GPs get asked for seven-day prescriptions for Monitored Dosage System (MDS)/Multi-compartment compliance aid (MCA) dispensing?

There are a small number of patients who satisfy the eligibility criteria for the supply of an MDS/MCA tray under the Equality Act 2010, and the national NHS community pharmacy funding contains a contribution towards the provision of such auxiliary aids. Additionally, in the past some PCTs commissioned local enhanced services for dispensing and managing those patients who require compliance aids and additional pharmaceutical support in their own homes. Some local commissioners may choose to continue this provision.

If it is clinically appropriate for a patient to receive a seven-day supply of their medicines because their treatment may need regular review and/or frequent changes, then a seven-day prescribing interval may be written and the pharmacy will provide a seven-day supply of the medicines to the patient. Pharmacists may discuss seven day

prescriptions with prescribers if they have decided to provide medicines in MDS/MCA trays, because of the dangers of wastage if treatment changes.

However, some pharmacists may request a seven-day prescription in an attempt to cover the cost of MDS/MCA trays for other patients that do not fall within the criteria of the Equality Act 2010. It is important that patients are not given the expectation that their medicines will be dispensed in an MDS/MCA, unless they satisfy the eligibility criteria or a local service to manage patients who require compliance aids has been commissioned.

Do pharmacists and pharmacy staff advise patients about the minimal benefits of some OTC medicines that may have limited therapeutic value?

The sale of OTC medicines is a vital aspect to the self management of many minor health problems that may otherwise require a GP consultation. Licensing regulations and continuous scrutiny by the Medicines and Healthcare products Regulatory Agency (MHRA) ensure that OTC medicines are only available for purchase if considered safe, are made to acceptable quality standards, are proved to be effective for their clinical indication and have appropriate labelling.

Many medicines are available from non pharmacies where no professional advice is available. But, in pharmacies, medicines can only be sold by a person who is competent to do so, and is either a pharmacist or subject to supervision by a pharmacist.

Publicity for OTC medicines can lead to members of the public selecting medicines that are unsuitable and the availability of professional advice in a pharmacy prevents many inappropriate purchases.

In providing professional advice and selling medicines (either personally or under their supervision) pharmacists must comply with provisions in their professional code, and the safety and welfare of the patient are primary concerns.

Do pharmacy contractors set the reimbursement costs of 'Specials' medicines?

Specials have not been subjected to testing for safety, quality and efficacy, and prescribers will need to explain the risks when they discuss treatment alternatives with the patient. The reimbursement price of many 'Specials' is set out in the Drug Tariff. Items not listed in the Drug Tariff will be reimbursed at the price charged by the manufacturer. 'Specials' manufacturers are often highly specialised units that make products to order. The cost of carrying out appropriate testing of a product before release can amount to several hundred pounds, so as well as the clinical considerations, these bespoke products should be prescribed only where there is no suitably licensed alternative. Pharmacists are ideally placed to advise GPs on suitable products. The pharmacist is eligible to be reimbursed for these products in accordance with the national arrangements described above.

Within the community pharmacy, who can access patient records?

As is the case with GP practices, all pharmacy staff engaged in supporting NHS activity must comply with the Data Protection Act, NHS information governance requirements and the NHS Confidentiality Code of Practice. As such, access to the patient medication record will be limited to those members of staff involved in providing pharmaceutical care to the particular patient.

The same NHS information governance requirements apply to community pharmacies and general practices.

Will community pharmacy premises be suitable for future locally commissioned and enhanced services?

Pharmacy contractors have invested significantly in the standards of their premises and continuously monitor patient and public feedback, to ensure the expectations of the service users are met. As part of the specifications for locally commissioned or enhanced services, commissioners can require contractors who provide these services to meet specific premises requirements. There are also premises requirements for some advanced services, for example to provide MURs and/or the NMS, contractors must have a confidential consultation area that meets certain criteria to ensure patients and pharmacists can sit down and have confidential consultations without being overheard.

How do repeat prescription ordering systems work?

Over recent years as repeat prescription volumes have increased many pharmacies have responded by introducing a prescription reordering service for their patients. This service consists of the safe storage of the reorder portion of the patient's monthly prescription, together with a commitment to present the reorder form to the GP practice when instructed to do so by the patient. Some pharmacies then collect the new repeat prescription from the practice and may provide home delivery. Some pharmacies have also introduced an 'express reordering service' that enables a patient taking a regular medication to predict their requirements for the next supply period when they receive their current supply.

Whichever system is in operation within the pharmacy, the pharmacist needs to ensure that requests for repeats are triggered by the patient, and that decisions to reorder are not taken by pharmacy staff without input from the patient.

Such reordering systems have become, in the main, a well accepted process for patients and GP practices. The efficiency and smooth running of the systems is dependent on strong and effective communication links between GP practices and their local pharmacies. To avoid the repeat reordering service creating additional workload for practices, or additional expenditure for the NHS, it is essential that pharmacies and practices understand each others' working procedures, workload pressures and where there may be inefficiencies and potential risks resulting from the service.

Some of these services have been introduced by pharmacies because the repeat dispensing service has not been fully utilised by GPs. GP practices may wish to consider the significant benefits that repeat dispensing (batch dispensing) can bring to all those involved in the process.

Useful websites for further information

www.pharmacyregulation.org – General Pharmaceutical Society website for details on regulatory requirements for pharmacists

www.rpharms.com – Royal Pharmaceutical Society website for details on the professional leadership body for pharmacy

www.pcc-cic.org.uk – Primary Care Commissioning for details on Pharmacist with a Special Interest

www.nhsemployers.org – NHS Employers website for information and guidance on aspects of the Community Pharmacy Contractual Framework and joint working between General Practice and Pharmacy

www.psnc.org.uk – Pharmaceutical Services Negotiating Committee website for details on the Community Pharmacy Contractual Framework

<https://www.gov.uk/government/organisations/department-of-health> – Department of Health website for pharmaceutical services Directions, regulations, approved particulars and so forth.

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