26 September 2019

FILE REF: SHA/22187

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DECISION MAKING BODY: NHS COMMISSIONING BOARD (OPERATING AS NHS ENGLAND AND NHS IMPROVEMENT) (“NHS ENGLAND”)

GMS CONTRACTOR: DRS HICKMAN AND CHAPMAN
NORTH CURRY HEALTH CENTRE
GREENWAY
NORTH CURRY
TAUNTON
SOMERSET
TA3 6NQ

DISPUTE RESOLUTION – NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES CONTRACTS) REGULATIONS 2015

RE: 2017/2018 DISPENSARY SERVICES QUALITY SCHEME (“DSQS”)

1. Outcome

1.1 I determine that NHS England is entitled to recover the monies paid to the Contractor in respect of DSQS payment as the Contractor did not meet the eligibility condition for payment of DSQS payment set out in the SFE.
1 INTRODUCTION

1.1 NHS England referred the dispute in relation to the Contractor’s general medical services contract (the “Contract”) for dispute resolution under the provisions of paragraph 83 of the National Health Service (General Medical Services Contracts) Regulations 2015 (the “Regulations”).

1.2 The Contract is not an NHS Contract. The Contractor’s representative has agreed to NHS Resolution’s jurisdiction to deal with the dispute.

1.3 The Secretary of State for Health and Social Care has directed that NHS Resolution exercise the functions of dispute resolution on his behalf. I, as an authorised officer of NHS Resolution, have made this determination.

2 APPLICATION FOR DISPUTE RESOLUTION

2.1 By letter dated 18 July 2019 NHS England applied to NHS Resolution for dispute resolution.

2.2 The application relates to NHS England’s proposed recovery of monies from the Contractor as a result of the Contractor allegedly not meeting the entitlement conditions for payment for its participation in the Dispensary Services Quality Scheme 2017/18 (“DSQS”).

2.3 I have had regard to the following documents made available to me in consideration of this matter to ensure the just, expeditious, economical and final determination of this dispute:

2.3.1 letter from NHS England dated 19 July 2019 together with enclosures;

2.3.2 letter from Contractor’s Representative (Veale Wasborough Vizards LLP) dated 29 July 2019;
2.3.3 letter from Contractor’s Representative dated 6 August 2019 together with enclosures;

2.3.4 letter from NHS England’s Representative (Bevan Brittan LLP) dated 20 August 2019 together with enclosures;

2.3.5 letter from NHS England c/o its Representative dated 23 August 2019 together with enclosures; and

2.3.6 letter from Contractor’s Representative, dated 3 September 2019.

2.4 I note that both parties are represented. For ease of reference, I will refer in this determination to communications and materials provided by the Contractor and/or NHS England. These references should be read as referring to the communications and materials submitted by the parties’ representatives.

3. CONSIDERATION

NHS ENGLAND’S APPLICATION

NHS England’s application sets out the background and the grounds to its dispute. The application states the following:

3.1 NHS England and NHS Improvement wishes to refer the following dispute to the formal NHS dispute resolution procedure:

3.2 Commissioner: NHS England and NHS Improvement, South West (known as NHS England prior to 1 April 2019) – postal and email address as above

3.3 Contractor: Drs Hickman and Chapman, North Curry Health Centre, Greenway, North Curry, Taunton, TA3 6NQ – email: #

3.4 Nature and circumstances of the dispute: Decision by NHS England to recover from the contractor as an overpayment the sum of £9,956.22, being an amount paid to the contractor ‘on account’ in relation to the 2017/18 Dispensary Services Quality Scheme (DSQS).

3.5 Having reviewed the evidence submitted by the contractor to NHS England as part of the 2017/18 DSQS, NHS England determined that the contractor did not undertake a clinical audit of dispensing services as required.

3.6 NHS England has therefore concluded that the contractor did not comply with the entitlement conditions for the payment and that it should be recovered as an overpayment by deduction of an equivalent amount from the contractor’s payments.

3.7 Local dispute resolution undertaken: NHS England and NHS Improvement has undertaken local dispute resolution by offering the contractor the opportunity to make written representations to NHS England and NHS Improvement, which it did. NHS England and NHS Improvement then offered the contractor the opportunity to make oral representations at a Local Dispute Resolution Meeting held on 24 May 2019. The contractor attended the meeting and made oral representations. Both the written and oral representations were considered by a panel.

3.8 The outcome of that meeting was that NHS England and NHS Improvement confirmed its original decision. The outcome was conveyed to the contractor by a letter emailed to the contractor on 28 May 2019.

3.9 Reason for referring to the formal NHS dispute resolution procedure:
3.10 NHS England and NHS Improvement considers that it has done all it can to resolve this dispute. In the light of subsequent emails from the contractor indicating that it does not accept the outcome of the Local Dispute Resolution Meeting, and in order to progress the matter to a final conclusion, NHS England and NHS Improvement now refers the dispute for formal dispute resolution.

3.11 **Outcome requested:** That NHS England’s decision to recover the sum of £9,956.22 from the contractor is upheld.

3.12 **Contractual information attached:**

3.12.1 GMS Contract dated 25 March 2004,

3.12.2 GMS Statement of Financial Entitlements 2013 (see sections 24 and 25, and appendix H) – we do not believe that any of the subsequent amendments to the SFE are relevant to this dispute,

3.12.3 Dispensary Services Quality Scheme specification and guidance,

3.12.4 Signed agreement by the contractor to participate in the 2017/18 Dispensary Services Quality Scheme.

3.12.5 NHS England and NHS Improvement has assembled a file of relevant papers which we will provide to Primary Care Appeals when requested to do so, along with our representations regarding the dispute.

4. **CONTRACTOR LETTER**

It was noted that the GMS Contract was not an NHS Contract. The Contractor was invited to confirm if it was in agreement to proceed to dispute resolution.

4.1 The Contractor’s Representative is instructed by North Curry Health Centre in respect of this matter. The Contractor’s Representative note the content of your letter dated 23 July 2019.

4.2 As you know, the Contractor’s Representative has not seen the application that NHS England has made for dispute resolution.

4.3 The dispute between the parties concerns NHS England’s decision to fail the Contractor’s DSQS Audit.

4.4 When the Contractor received your letter dated 23 July 2019, it was in the process of preparing its own application to NHS Resolution in respect of NHS England’s decision to fail its DSQS Audit. That application was to appeal the decision of NHS England and to seek certain determinations.

4.5 Accordingly, on condition that the appeal and determinations sought by the Contractor will be considered as part of NHS England’s application for dispute resolution, the Contractor will agree to NHS Resolution’s jurisdiction to deal with the dispute.

5. **CONTRACTOR’S REPRESENTATIONS**

By letter dated 6 August 2019, the Contractor submitted its representations to the application. The Contractor submitted a bundle of papers in support of its representations to which I have had regard. The Contractor states:

Parties to the dispute
5.1 This is the First Submission of Dr James Hickman MBE and Dr Nicholas Chapman (the Contractor), the partners of North Curry Health Centre of Greenway, North Curry, Taunton, Somerset, TA3 6NQ in response to an application for dispute resolution made to NHS Resolution by NHS England (NHSE).

5.2 The applicant is NHSE, acting through NHS South West Direct Commissioning Contracting Group (DCCG). Any references to the Commissioner are to be read as NHSE and the DCCG as appropriate.

5.3 For the avoidance of any doubt, as per the letter from the Contractor’s solicitors Veale Wasbrough Vizards LLP to NHS Resolution dated 29 July 2019 (Letter)(at Appendix 6, pages 64 to 65 of the exhibit), the Contractor was in the process of preparing an application to NHS Resolution in respect of its dispute with the Commissioner when it was notified of the Commissioner’s application the NHS Resolution. By the Letter, the Contractor agreed to accept NHS Resolution’s jurisdiction to deal with the dispute following the Commissioner’s application on the condition that the Contractor’s appeal of the Commissioner’s decision and the determinations sought by it are considered as part of the Commissioner’s application for dispute resolution.

Summary of the dispute

5.4 The Contractor claims that the Commissioner has incorrectly determined that the Contractor failed an annual audit of its dispensing services (Services) in respect of the year 1 April 2017 to 31 March 2018 (Service Period), in accordance with the Dispensing Services Quality Scheme (DSQS) specifications. The Commissioner has asserted that it is entitled to clawback £9,956 (Payment) that it paid to the Contractor in March 2018 in relation to the provision of the Services during the Service Period as a result of the Commissioner’s incorrect determination.

5.5 The Contractor claims that the Commissioner:

5.5.1 was incorrect to determine that it failed the DSQS audit of its Services for the Service Period; and

5.5.2 is not entitled to clawback any monies from the Contractor in respect of the provision of the Services in the Service Period or at all.

Local dispute resolution

5.6 The parties have been corresponding regarding this dispute since the Commissioner wrote to the Contractor on 2 January 2019, informing it of the decision to fail its DSQS audit in respect of the provision of the Services during the Service Period and the fact that the Payment would need to be repaid as a result Appendix 1 (pages 1 to 3 of the exhibit).

5.7 On 24 May 2019 the Contractor attended a meeting with the Commissioner to appeal the decision notified to it on 2 January 2019. The Contractor (represented by Dr Chapman, supported by Guy Miles of the Somerset Local Medical Committee) and the Commissioner (represented by David Ward, Assistant Contract Manager) presented their respective cases to the Commissioner’s panel (Laila Pennington, Janet Newport, Jenny Collins and Philip Kirby).

5.8 By a letter dated 28 May 2019 Appendix 2 (pages 4 to 8 of the exhibit), the Commissioner’s panel notified the Contractor that its appeal had not been successful and that the panel had determined that the Commissioner’s original decision was correct.

5.9 In the light of the above, the parties have exhausted local dispute resolution procedures.
5.10 The Contractor is appealing against the Commissioner's decisions dated 2 January and 28 May 2019. The Contractor maintains that:

5.10.1 its audit topic selection is an acceptable and reasonable choice for the purposes of the DSQS audit as per the specifications of the DSQS, based upon the arguments set forth below; and

5.10.1.1 the Commissioner has a duty to treat all practices equally and to apply its assessment criteria consistently, which it has failed to do in failing the Contractor's audit.

Factual background to the dispute

5.11 The Contractor's practice includes the operation of a dispensary. In providing the dispensary, the Contractor incurs additional costs and employs additional staff, without any guarantee as to the level of income that it will receive from delivery of dispensing services, but considers this is an important aspect of its role at the centre of a rural, elderly community. The Contractor must also submit an annual audit in accordance with DSQS specifications, published in 2007 Appendix 3 (pages 9 to 39 of the exhibit). The specification states at paragraph 3.1.3 [emphasis added]:

5.11.1 "The contractor must participate in contractor lead clinical audit of dispensing services.

5.11.2 Clinical audit seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change. Audit of dispensing services should include arrangements to assess the nature and quality of the advice provided to patients as part of the dispensing service." (at page 16 of the exhibit)

5.12 Pursuant to the DSQS specification, the Contractor must decide the subject matter of the audit to reflect upon the dispensary services provided with a view to enhancing and improving patient care and safety.

5.13 Upon passing the audit requirement, the Contractor is entitled to the Payment providing all the other criteria within the DSQS specification have been met: there is no dispute between the parties in relation to the remaining DSQS criteria.

5.14 The Contractor selected an audit topic of dispensary services performed at its dispensary and which it considered appropriate and beneficial for its dispensary with a view to the need "to improve patient care and outcomes".

5.15 The topic selected concerned the ordering of prescriptions by telephone. The audit collated information to establish why patients chose to telephone the dispensary to order medication and why those patients were not using Patient Access or an alternative method of ordering. Amongst other things, the audit's intention was to:

5.15.1 improve stock management by the dispensary by increasing use of Patient Access;

5.15.2 reduce the risk of dispensing errors;

5.15.3 improve the service provided to patients and their experience;

5.15.4 ascertain why patients contact the dispensary by telephone to order their prescriptions, rather than by Patient Access accessed via the EMIS online portal, which is the Practice's preference in accordance with NHS guidelines;
5.15.5 identify any possible barriers preventing patients from using Patient Access, a more efficient and safer method of ordering prescriptions than by telephone, and in so doing identifying solutions; and

5.15.6 promoting knowledge of and the use of Patient Access amongst patients, to improve risk management.

5.16 In selecting the above topic, the Contractor reasonably interpreted the term “dispensing services” to mean services carried out in its dispensary and by its dispensary staff in the performance of their dispensary duties. This definition, together with the lists of examples issued by the Commissioner as guidance to audit topic selection, have formed the basis of the Contractor’s selection of audit topics for the last 12 years. These topics have included both dispensing services and dispensing processes.

5.17 The Contractor has never received any negative feedback from the Commissioner over the past 12 years about its audits, including but not limited to feedback about:

5.17.1 the topics selected;

5.17.2 the level of detail provided in audits; or

5.17.3 the way in which audits were worded.

5.18 Accordingly, the Contractor has continued to select and submit audits based on its interpretation of “dispensing services” and used the example topics provided by the Commissioner as guidance in good faith that it had not made any error in interpretation and was fulfilling the requirement of the specification.

5.19 What is even more confusing is that the Contractor had performed this same audit in 2007 and the audit was passed in 2007, yet rejected in 2018, clearly demonstrating a lack of consistency from the Commissioner in the interpretation of the DSQS specification.

5.20 For the avoidance of any doubt, a definition of what constitutes “dispensing services” is not provided in the DSQS specification. In order to conduct an audit, dispensing practices have had to make their own interpretation of the term and rely upon guidance issued to support the DSQS specification. Guidance has comprised of lists of examples of acceptable audit topics (see attached example from the Commissioner, “Examples of DSQS Clinical Audit Topics” at Appendix 7, pages 66 to 68 of the exhibit). These lists include examples of what are commonly understood by dispensing practices and their representative bodies (e.g. Dispensing Doctors Association (“DDA”) and the British Medical Association (“BMA”)) to be dispensing services.

5.21 The Commissioner’s reason for rejecting the Contractor’s audit is incorrect. The Commissioner’s rationale that the audit of a dispensing service is not acceptable is contrary to the formal DSQS audit specification at paragraph 3.1.3 of the specification (quoted at paragraph [5.11] above). The Contractor’s audit was rejected on the basis that it is not an audit of a “dispensing process”. The expectation that a Practice conduct an audit of a dispensing process is not the expectation set forth in the DSQS specification which is the formal basis for the audit agreed by NHS England, the British Medical Association, and the Dispensing Doctors’ Association (“DDA”). The DSQS specification calls for an audit of “dispensing services”.

5.22 Furthermore, the Commissioner indicated that its decision to fail the Contractor’s audit was based on an opinion in a journalist’s article on the DDA’s website Appendix 4 (pages 40 to 42 of the exhibit). The article states that:

5.22.1 “The audit is an audit of dispensing processes (including advice given by dispensary staff to patients) and NOT prescribing or other related activities.
The general rule of thumb used by the AT will be that if the audit could be undertaken by a non-dispensing practice it is not a dispensing audit”.

5.23 The article is not part of the agreed DSQS specification and fails to acknowledge that a dispensing and a non-dispensing practice could undertake an audit on the same topic but the purpose, value and the learning from the audit will be very different for those two practices. In the Contractor’s practice, taking the repeat prescription orders is a key role of the dispensary because amongst other things the dispensary is able to offer advice to patients at an early stage (where appropriate), raise issues with doctors before the prescribing stage and manage their stocks of medicines safely.

5.24 For the avoidance of any doubt, enclosed at Appendix 5 (pages 43 to 63 of the exhibit) is a spreadsheet of audit topics submitted to NHSE in the South West of England in completion of the DSQS between 2013/2014 and 2018/2019. This information was obtained through a Freedom Of Information Act request.

5.24.1 The Contractor's audit topic for the Service Period was "Phone - Ordering of Prescriptions". This was rejected by the letter dated 2 January 2019.

5.24.2 In 2017-2018 an audit from another practice that was accepted was titled (page 59 of the exhibit):

“This audit will look at how patients are currently ordering their medication with a view to promoting the use of online access in line with NHS guidance. Auditing the repeat prescription process will identify interruptions during the dispensing process, promoting alternative ways of ordering repeat medication will potentially reduce the risk of dispensing errors” [sic].

5.25 The audit referred to in paragraph 4.12.2 [5.24.2 of this determination – all references to paragraphs in parties’ comments is followed by the relevant paragraph of this determination in square brackets] was accepted. It does clearly explain the purpose of the audit and how it will benefit patients. It was written in a more expansive and explanatory matter than that of the Contractor but it is clearly in respect of the same thing (manner of taking repeat prescription orders in the dispensary) and had the same intention and goal as that of the Contractor. However, the Contractor's audit on the same topic was rejected. The Contractor attempted to explain the purpose within their audit, highlighting the fact that ordering repeat prescriptions on the internet was an accurate, safe and preferred approach but ultimately a problem for a practice with a significant elderly population, meaning the practice would need to continue engaging with those patients and promoting electronic ordering. The Commissioner should have discussed the Contractor's audit with them to better understand it.

5.26 Other items of note on the spread sheet at Appendix 5 include:

5.26.1 In 2015/2016 the following audits were deemed acceptable (page 54 of the exhibit):

5.26.1.1 (a) "To make the process of obtaining repeat prescriptions by our rural dispensing patients easier. Evening out work load. Reducing need of patients having to travel to the surgery twice monthly thus reducing fuel."

5.26.1.2 (b) "We have recently experimented with taking requests for repeats when patient collects their medication. This is getting very positive responses from patients who like the service as it proving much more efficient with less Owings and improved workflow. Patients do not then have to make a separate visit to deposit their next request and dispensers can control their workflow. It is proving efficient over times of bank holidays. We are undertaking a questionnaire regarding this
new service both to get any feedback and to raise awareness of those who have not seen it yet.

5.26.2 In 2014 / 2015 the following audit titles / topics were deemed acceptable (page 48 of the exhibit):

5.26.2.1(a) "Repeat Prescription Audit"

5.26.2.2(b) "Repeat prescription ordering"

5.26.3 In 2013 / 2014 the following audit titles / topics were deemed acceptable pages 45 and 46 of the exhibit):

5.26.3.1(a) "An audit focussing on the process from ordering – whether by phone, fax, email, website, post, online access or in person to completion and collection. How we can improve our services thus making the process of ordering medication as quickly, conveniently, accurately and efficiently as possible."

5.26.3.2(b) "Repeat dispensing"

5.26.4 The Contractor also filed an audit in 2006/7 on the dispensary taking repeat prescription orders (the same audit area as in 2018). The 2007 audit was accepted by the Commissioner in 2007 yet the same audit topic was failed by the same NHS employee in 2018.

5.26.5 We also note that in 2017 / 2018 two practices were invited to submit replacement audits after the Commissioner did not approve their first submission (page 60 of the exhibit). Their replacement audits were accepted. The Contractor was not provided with any opportunity to provide an alternative audit for 2017 / 2018 unlike those two practices. This further demonstrates inconsistency in the approach taken to the other practices. All practices which had their audit topic rejected should have had the opportunity to submit a replacement audit.

5.26.6 In 2018 / 2019 eight practices were invited to submit replacement audits after the Commissioner did not approve their first submission (page 62 of the exhibit). Their replacement audits were accepted. Again, in the interests of fairness, all practices which had their audit topic rejected should have had the opportunity to submit a replacement audit.

5.27 The audit assessment criteria are not transparent. A review of the audit titles and whether or not they passed or failed does not reveal the logic or criteria applied by the Commissioner when deciding whether an audit has passed. Providing more transparent explanation of the logic and criteria used to pass or fail an audit would leave the issue less open to confusion and interpretation and reduce the risk of a practice successfully providing the services for a year but not getting reimbursed fully for that due to a technicality or difference of interpretation.

Impact of any decision to not reimburse the Contractor

5.28 The additional costs incurred by dispensing practices in order to provide dispensing services are paid for, in part, by participating in the DSQS. Failing an audit results in clawback of funding paid to the Contractor over a year ago in respect of its provision of the Services during the Service Period.

5.29 In this instance, the penalty for the Contractor is the clawback of the Payment paid to it for the provision of the Services during the Service Period.

Inconsistent approach by the Commissioner
5.30 The Commissioner’s interpretation of paragraph 3.1.3 and its decision to reject the Contractor’s audit topic are not consistent.

5.31 Unfortunately, it appears that the Commissioner now interprets paragraph 3.1.3 differently to the Contractor and to its own previous interpretation of the DSQS specification. It is asking for an audit on dispensing process which is not in the specification and has failed the Contractor’s audit as a result. The Contractor takes issue with the Commissioner’s decision and considers it should be overturned not least because:

5.31.1 There is a lack of consistency in the interpretation of the specification by the Commissioner who accepted an audit of the same title and subject matter in 2007 yet rejected it in 2018.

5.31.2 There is lack of consistency in how the Commissioner assessed other Contractors who performed the same audit. A Freedom of Information Act request has shown that another Contractor who performed the same audit in 2018 had their audit accepted by the same Commissioner.

5.31.3 Lack of consistency in dealing with failed audits, allowing some Contractors to resubmit an audit but not offering this opportunity to other/ or all Contractors. Two other Contractors with audits initially rejected by the Commissioner in 2018 were allowed to resubmit audits and thus receive the DSQS payment. This highlights that some Contractors are treated more favourably than others.

5.31.4 The criterion used to reject the Contractor’s audit is not a formal DSQS audit specification. The Commissioner’s expectation that the Contractor conduct an audit of a dispensing process is not the expectation set forth in the DSQS specification which is the formal basis for the audit agreed by NHS England, the British Medical Association, and the Dispensing Doctors’ Association. The DSQS specification calls for an audit of a “dispensing service”.

Summary

5.32 In summary, the Contractor asserts that the decision to reject its audit for the Services during the Service Period and to claw back the Payment was incorrect. It also understands that the issues that have affected it have also been experienced by other practices.

5.33 The Contractors (and other practices) are required to comply with the DSQS specification in order to qualify for the Payment. The DSQS specification clearly highlights at paragraph 3.1.3 that “The contractor must participate in contractor lead clinical audit of dispensing services”. No definition of “dispensing services” is provided, nor is the scope of those services set out.

5.33.1 The aim of the audit is to help a dispensary in a dispensing practice “improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change”. The Contractor’s audit complied with this.

5.34 The Commissioner and the Contractor interpret the requirements of the DSQS specification to “participate in contractor lead clinical audit of dispensing services” differently from one another. There is no definition of “dispensing services” in the DSQS specification and so a general definition must be applied. It is incorrect to state that a “clinical audit of dispensing services” must be an audit of dispensing processes not dispensing services, when that is exactly what the guidance in the DSQS specification clearly refers to.

5.35 The Commissioner has had an inconsistent approach. As highlighted in sections 4 and 6 [5.11 to 5.27 and 5.30 to 5.31.4] above, the Commissioner has a history of:
5.35.1 accepting some audits on the methods used by a dispensary to take repeat prescription and rejecting others, often in the same year (seemingly interpreting the scope of those audits and/or applying its interpretation of the DSQS specification differently from case to case). To this end, we refer to paragraph 4.12 [5.24] above; and

5.35.2 accepting an audit in 2006/7 yet rejecting an audit on the same topic in 2018; and

5.35.3 inviting some practices which have had audits rejected to submit replacement audits, while others do not receive the same invitation. There is no good reason why all practices should not be given an explanation of why their audit is deemed unacceptable and an opportunity to either correct any problems identified by the Commissioner or to submit an entirely new audit.

5.36 By way of a wider point, this issue is particularly important in the light of the fact that the payment awarded for passing the audit process is part of the payment dispensing practices retrospectively receive in respect of the provision of the Services for a given service period. This rigid approach to passing and failing audits, inconsistencies in the approach of commissioning authorities in their approach and the potential financial consequences of being deemed to have failed an audit risks disincentivising practices (typically rural, with elderly populations and poor transport) from engaging in the DSQS, which is designed to maintain standards and safety levels.

The claim

5.37 The Contractor invites NHS Resolution to determine the following:

5.37.1 the Commissioner has incorrectly determined that the Contractor failed its DSQS audit in respect of the provision of the Services during the Service Period; and

5.37.2 the Commissioner is not entitled to clawback the Payment paid to the Contractor in relation to its provision of the Services during the Service Period;

5.37.3 the Commissioner must provide to all practices that it deems to have failed an audit:

5.37.3.1 an explanation as to the reason for the deemed failure, by reference to the specification; and

5.37.3.2 a second opportunity to either correct any issues identified by the Commissioner with the audit or to conduct and file a replacement audit.

5.38 The Contractor also suggests that to avoid further disputes of this nature there should be further discussion with the stakeholders (BMA, DDA and NHSE) on how the specification should be interpreted and that a list of appropriate audit topics be circulated to all practices at least six months prior to the audit's due date.

6. NHS ENGLAND'S REPRESENTATIONS

By letter dated 20 August 2019, NHS England submitted its representations to the application. NHS England submitted a bundle of papers in support of its representations to which I have had regard. NHS England states:

6.1 We are instructed on behalf of NHS England and NHS Improvement in relation to the above matter and should be grateful if you would note our interest.
6.2 Please find enclosed our client’s representations. Our client has separately uploaded the documents referred to in the enclosed representations via NHS Resolution’s Document Transfer System.

6.3 Our client was copied into the Practice’s written representations on 6 August 2019 and will be preparing separate written observations in response when invited to do so by NHS Resolution.

6.4 Finally, we note this appeal raises similar issues as two other appeals that are currently with the PCA (references: SHA/22143 and SHA/22144). Accordingly, in the interests of consistency of decision-making, we consider it would be helpful to have the three appeals considered together by the same adjudicator.

NHS England’s Representations

6.5 These are NHS England’s representations regarding the dispute between it and North Curry Health Centre ("the Practice"). Please note that from 1 April 2019, NHS England became known as NHS England and NHS Improvement. However, for ease and consistency, we refer only to NHS England throughout these representations.

6.6 Please note NHS England was copied into the Practice’s written representations on 6 August 2019 and will be preparing separate written observations in response when invited to do so by NHS Resolution.

Evidence attached

6.7 We attach a bundle of evidence, which is split into five PDF files, plus a chronology and index. The five files are:

6.7.1 A General papers.pdf
6.7.2 B NHSE papers.pdf
6.7.3 C North Curry papers.pdf
6.7.4 D Presentations notes outcome.pdf
6.7.5 Other documents.pdf

6.8 In addition we would also refer the adjudicator to the Contractor’s GMS contract dated 2004, including variations up to August 2015, which was attached to our application for dispute resolution.

6.9 Files A, B and C are the three sets of papers as considered by the local dispute resolution (LDR) meeting. So that the adjudicator can see what information the LDR meeting had available to it we have left those papers in the sequence that they were presented to the LDR meeting, even though a chronological arrangement of the evidence would be different, and other information which we have provided would (chronologically) sit in amongst those pages. However the chronology/index which we have provided lists all of the evidence in date order with relevant page references and so will, we trust, assist the adjudicator in navigating the files.

Relevant SFE provisions

Dispensary Services Quality Scheme

6.10 This dispute concerns the Dispensary Services Quality Scheme ("DSQS"), which is a voluntary scheme in which contractors who are authorised or required to provide dispensing services may choose to participate. The terms of the scheme (including
eligibility to receive an annual Dispensary Services Quality Payment) are set out in section 24 and Annex H to the General Medical Services Statement of Financial Entitlements Directions 2013 (“SFE”) (see file A, pages 7-14).

6.11 Pursuant to paragraph 24.3 of the SFE, contractors who participate in the DSQS are eligible to receive an annual Dispensary Services Quality Payment if:

6.11.1 they satisfy certain eligibility conditions (set out at paragraph 24.4 of the SFE – “the Eligibility Conditions”), including providing a written undertaking each financial year and co-operating with NHS England in reviewing their Dispensary Services Quality Scheme arrangements; and

6.11.2 NHS England is satisfied, following a review of the contractor’s arrangements, that the contractor is providing the required level of service and achieving the required standards set out in Annex H to the SFE (see below).

6.12 The DSQS is an “all or nothing” scheme in that contractors are only eligible for payment provided they meet the conditions set out in the SFE.

6.13 On 25 May 2017 the Practice signed-up to participate in the DSQS for 2017/18, in doing so undertaking to “perform the services, and achieve the standards, set out in Annex H” of the SFE and to “co-operate with NHS England in reviewing our DSQS arrangements” (see file C, page 1).

Payment on Account and Overpayment recovery

6.14 NHS England made a payment to the Practice at the end of April 2018 of £9,956.22 in respect of the 2017/18 DSQS. Prior to doing so, on 6 April 2018, NHS England informed dispensing practices (including the Practice), via a bulletin that:

6.14.1 “We have arranged for payments to be made to all practices who have participated in the 2017/2018 Dispensary Services Quality Scheme (DSQS). As the assessment process is not yet complete this will be an ‘on account’ payment, and subject to recovery later if a practice is assessed as not adequately meeting the requirements of the DSQS.” (see file E, page 6)

6.15 Subsequently, for the reasons explained further below, NHS England concluded that the Practice had not complied with the Eligibility Conditions for a DSQS payment for 2017/18. NHS England has therefore sought to recover the payment of £9,956.22 as an overpayment under paragraph 25.1 of the SFE (see file E, page 7).

Requirements relating to clinical audits of dispensing services

6.16 This dispute concerns the acceptability of the evidence which the Practice submitted in respect of the requirement, as part of the DSQS, to undertake a clinical audit of dispensing services.

6.17 The following provision of Annex H of the SFE is relevant (see file A, page 12):

6.17.1 H.1.3 The contractor must participate in contractor lead clinical audit of dispensing services. Clinical audit seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change. Audit of dispensing services should include arrangements to assess the nature and quality of the advice provided to patients as part of the dispensing service.

6.18 Also relevant is the DSQS specification and guidance issued in 2006 (see file A, pages 15-41), specifically:
6.18.1 Paragraph 3.1.3 of the DSQS specification (see file A, page 19) which is worded identically to paragraph H.1.3 of the SFE, quoted above

6.18.2 Paragraph 6.1 of the DSQS guidance (see file A, page 30) which states:

6.18.2.1 Practices will wish to ensure that clinical audit programmes include the dispensing systems and assess the nature and quality of information given to patients by the staff dispensing in the practice, to help patients get the best from their prescribed medicines. It is recommended that the learning from these audits is shared with all practice staff, not only within the dispensary.

6.18.2.2 It is recommended that clinical audit programmes also use the information that the dispensary may provide to contribute to audits of other parts of the practice’s services e.g. patient information, records, critical incidents.

6.19 Also relevant is the definition of ‘dispensing services’ within clause 1 of the Practice’s GMS contract.

6.20 At the time that the 2017/18 DSQS was undertaken, and also when NHS England’s decision was made and the Local Dispute Resolution meeting was held, that definition was worded as follows (see the contract variation notice dated July 2011, page 281 of the copy of the contract which was included with the application for dispute resolution):

6.20.1 “dispensing services” means the provision of drugs, medicines or appliances that may be provided as pharmaceutical services by a medical practitioner in accordance with arrangements made under regulation 60 of the pharmaceutical regulations.

6.21 Following the issuing of the September 2015 GMS contract variation, which took effect from 11 June 2019, the definition is now worded as follows (page 15 of file E):

6.21.1 “dispensing services” means the provision of drugs, medicines or appliances that may be provided as pharmaceutical services by a medical practitioner in accordance with arrangements made under section 126 (arrangements for pharmaceutical services) and section 129 (regulations as to pharmaceutical services) of the 2006 Act.”

6.22 In our view the inclusion of the out-of-date statutory reference in the definition at the relevant times makes no difference to the interpretation of the definition, and if necessary we would refer the adjudicator to clause 2.7 of the GMS contract (on page 26 of the contract file) which provides that statutory references should, when required, be read as referring to revised provisions.

6.23 From the above provisions, NHS England would derive the following key requirements for a clinical audit of dispensing services:

6.23.1 ‘Contractor led’ – it is for participating practices to choose the topic of their clinical audit, however it must still meet the other criteria;

6.23.2 ‘clinical audit’ – what is undertaken should relate to ensuring that the clinical service (in this case, dispensing) is being provided to an appropriate standard, and identifying any improvements that may be required;

6.23.3 ‘of dispensing services’ – the audit must be about dispensing services, not other parts of the practice’s service. In this respect, ‘dispensing services’ means activities connected with ‘the provision’ of drugs and medicines as per the definition in the GMS contract. In relation to this, NHS England has sought
to provide further guidance (see below) to practices to clarify that dispensing services are considered separate from prescribing services;

6.23.4 ‘should include arrangements to assess the nature and quality of the advice provided to patients as part of the dispensing service’ – NHS England has taken the view that this is quite limiting and so has not insisted on audits being focussed on the advice given to patients.

6.24 On 18 July 2017 NHS England wrote to practices who had signed up to participate in the DSQS for 2017/18 to provide details of the assessment process (see file A, pages 42-59). Included within that was additional guidance regarding the clinical audit of dispensing services which practices would need to undertake.

6.25 We would draw the adjudicator’s attention to the following statements within that letter and guidance:

6.25.1 file A, page 44 – the paragraph headed ‘Audits’, in particular the statement “This is a tool for quality assurance and/or quality improvement and must be focussed on dispensing services, rather than prescribing by the GPs. The audit should assess the safety, accuracy or efficiency of dispensing (or associated processes), or the quality of information given to patients about their medication.”

6.25.2 file A, page 55 – the second bullet states “Clinical audits should … be focused on dispensing services, rather than prescribing by the GPs – our rule of thumb is that if the audit could have been done equally well by a non-dispensing practice then it is probably not really about the dispensary” (emphasis in the original).

6.26 In respect of the applicability of the additional guidance attached to the letter of 18 July 2017, we would refer the adjudicator to clause 499 of the GMS Contract (on page 220 of the contract file) which provides that a contractor must have regard to all relevant guidance issued by the PCT (which is now to be read as referring to the NHS Commissioning Board, i.e. NHS England). Accordingly, we consider that the Practice has a contractual duty to have regard to any guidance issued by NHS England in relation to DSQS and so, in this case, to the guidance we issued regarding requirements and expectations in respect of the contractor-led clinical audit.

6.27 We also consider that, by virtue of the provisions in paragraph 24.3(c) of the SFE that refer to the Board [NHS England] “being satisfied … that the contractor is providing the required level of service and is achieving the required standards” (see file A, page 7), NHS England is entitled to review and consider whether what a contractor has submitted in respect of the DSQS clinical audit requirement is sufficient to meet the requirements of the SFE, including that it is a clinical audit of dispensing services.

The Practice’s DSQS 2017/18 evidence relating to clinical audits of dispensing services

6.28 The practice submitted its evidence relating to the 2017/18 DSQS to NHS England on 19 April 2018. Included as an attachment was a document headed “Dispensary Audit 2017-18” (see file C, pages 8-10), and the title of the audit was:

6.28.1 Phone – Ordering of prescriptions.

6.29 For convenience, in this letter this document is referred to as ‘the audit’.

NHS England’s initial assessment of the audit

6.30 NHS England considered whether the first audit met the requirements for a clinical audit of dispensing services, and concluded that it did not.
6.31 This decision was conveyed to the Practice in a letter dated 2 January 2019 (see file C, pages 12-14). In NHS England’s view:

6.32 While the processing of requests is carried out by dispensary staff it is not in act a dispensing process, but part of the prescribing process. Therefore this was not an audit of the dispensing services provided by the practice. (see file C, page 14; emphasis in original)

6.33 The letter went on to state that NHS England had determined that the Practice had not complied with the entitlement conditions for the DSQS payment for 2017/18, and therefore NHS England intended to recover the payment which had been made ‘on account’ (pursuant to paragraph 25.1 of the SFE).

6.34 The letter of 2 January 2019 informed the practice that it could invoke the local dispute resolution procedure if it disagreed with NHS England’s decision.

Local Dispute Resolution (LDR)

6.35 The Practice duly invoked the LDR procedure, setting out its reasons in full in a letter dated 22 January 2019 (see file C, pages 18-20).

6.36 On 13 March 2019 NHS England emailed the Practice to invite the Practice to attend a LDR meeting on 11 April 2019 (see file C, page 21). The Practice responded on 15 March 2019 asking for an alternative date (see file C, page 22).

6.37 On 2 May 2019 NHS England emailed the Practice (see file D, page 2) proposing an alternative date of 24 May 2019 for the LDR meeting. Attached to the email were the papers which comprise files A, B (pages 1-4) and C, and the practice was asked to advise NHS England if any relevant papers were missing.

6.38 The Practice responded on 13 May 2019 to accept the proposed date (see file D, page 3).

6.39 On 22 May 2019 NHS England emailed the practice a document which is now contained within file B, pages 5-6 (see file D, page 4).

6.40 The LDR meeting was duly held on 24 May 2019 at 9.30am. The agenda is in file D, page 5. Those attending were:

6.40.1 the panel of decision-makers, who would decide whether to confirm or change the disputed decision:

6.40.1.1 Laila Pennington (chair), Head of Primary Care, NHS England and NHS Improvement

6.40.1.2 Janet Newport, Contract Manager (Pharmacy), NHS England and NHS Improvement

6.40.1.3 Jenny Collins, Contract Manager (Medical), NHS England and NHS Improvement

6.40.1.4 Philip Kirby, Chief Officer of Avon Local Medical Committee (by telephone)

6.40.2 to present NHS England’s perspective on the dispute: David Ward, Assistant Contract Manager (Pharmacy), NHS England and NHS Improvement

6.40.3 representing the Practice: Dr Nick Chapman, GP Partner, and Guy Miles, Somerset Local Medical Committee

6.41 All of those participating in the LDR had the papers contained in files A, B and C available to them.

6.42 At the LDR meeting, the Assistant Contract Manager (Pharmacy) firstly presented NHS England’s perspective on the dispute. The presentation given comprised the notes at file B pages 1-2 and file D pages 6-8 (see also the brief summary in the minutes of the meeting at file D page 11-12). A copy of those notes were provided to Dr Chapman, representing the Practice, and the panel members at the start of the LDR meeting.

6.43 In his presentation, the Assistant Contract Manager (Pharmacy) addressed the issue of why the audit was considered not to meet the criteria for a clinical audit of dispensing services, in doing so also commenting upon points made in the Practice’s letter of 22 January 2019:

6.43.1 The contractual ‘specification’ for prescribing of medication is the same for a nondispensing practice as it is for a dispensing practice. In dispensing practices, the contractual framework for the practice to then dispense the medication is separate from, and additional to, the prescribing process.

6.43.2 While the practice may well view and treat the prescribing and dispensing of medication as part of one holistic process that is not correct in terms of the contractual arrangements.

6.43.3 In summary, prescribing is the process of the patient requesting, and the prescriber authorising, the issue of medication; dispensing is the process of providing the medication to the patient.

6.43.4 If a function can be carried out in a non-dispensing practice, it is very likely to be part of the prescribing process, not the dispensing process.

6.43.5 This is reflected in the guidance NHS England gave to practices under cover of our letter in July 2017 (file A, page 55) that “if the audit could have been done equally well by a non-dispensing practice then it is probably not really about the dispensary”

6.43.6 In a post on the website of the Dispensing Doctors’ Association in February 2018 (so applying to the year in question), they say the same (see file B, pages 5-6):

6.43.6.1 The audit is an audit of dispensing processes (including advice given by dispensary staff to patients) and NOT prescribing or other practice related activities. The general rule of thumb used by the AT will be that if the audit could be undertaken by a non-dispensing practice it is not a dispensing clinical audit. (emphasis in the original)

6.43.7 This audit concerns the very start of the prescribing process.

6.43.8 Non-dispensing practices could potentially, in the same way as the Practice, receive requests for repeat prescriptions via a number of methods – via the Patient Access online service or by telephone, or by patients bringing in the request slip from the right-hand side of the previous prescription.

6.43.9 The argument put forward by the Practice is that the method of ordering is a risk factor within the dispensary – however it is not clear what risk(s) the audit was intended to address and we note this is not something that was addressed in the audit itself, nor was it further clarified in the dispute letter.
6.43.10 All practices – whether dispensing or not – receive requests for repeat medication and need to ensure that these are handled efficiently and that the correct medication is prescribed.

6.43.11 The Practice is choosing to use dispensing staff to receive and process requests for repeat medication. This does not have to be done by dispensing staff. In nondispensing practices it is done equally well by administrative staff.

6.43.12 Also it is the responsibility of the prescriber to ensure that they are prescribing the correct medication. Ensuring that the medication details are correct is therefore part of the prescribing process.

6.43.13 The practice’s reference to “the prescribing being performed at a later stage” (last sentence of point 2 in the Practice’s letter of 22 January 2019, see page 19 of file C) runs contrary to the contractual arrangements. Very little, if any, of the dispensing process can come before the prescribing. Until the prescriber has issued the prescription there is nothing to dispense. If the prescribing comes after the process covered by this audit, then the process covered by the audit is not part of dispensing.

6.43.14 There is nothing in the practicalities of this audit – or in the underlying aims, to the limited extent that those are stated – which could not have been done by a nondispensing practice.

6.44 In his presentation the Assistant Contract Manager (Pharmacy) also addressed the other issues raised in the Practice’s letter of 22 January 2019:

6.44.1 while the Practice undertaking Dispensing Reviews of the Use of Medicines (DRUMs) on considerably more than 10% of dispensing patients is laudable, it does not affect any of the other requirements of DSQS.

6.44.2 there is no obligation on NHS England to allow practices to revise and resubmit evidence that is considered to be non-compliant. However this dispute resolution process has given the practice an opportunity to provide whatever explanations and additional information it wished to NHS England for consideration, both in writing and verbally at the LDR meeting.

6.44.3 the delay in communicating the decision was longer than was desirable; the process followed, the dates concerned and the reasons behind that delay are set out on page 2 of file B.

6.44.4 regarding the Practice’s concerns about the impact of NHS England’s approach on engagement with DSQS, and bureaucracy: a quality incentive scheme such as DSQS cannot work effectively if NHS England does not properly consider the evidence provided by practices to support their compliance with the requirements and those practices which do not meet the requirements are paid in the same way as those which do.

6.45 Dr Chapman then presented the Practice’s perspective. Dr Chapman allowed NHS England to take a copy of his notes after the meeting for the purposes of the record, and these are included in file D at pages 9-10. Summaries are also contained in:

6.45.1 the notes of the meeting (file D, page 12-13), and

6.45.2 the letter conveying the outcome of the meeting (file D, pages 18-19).

6.46 We would ask the adjudicator to review and consider the content of both NHS England’s and the Practice’s presentations to the LDR meeting when considering this dispute.
6.47 After the presentations, and questions from members of the panel (as detailed in the notes, pages 12-13 of file D), the Assistant Contract Manager (Pharmacy) and the Practice’s representative left the meeting and the panel considered their decision. Notes of the panel’s discussion are contained in:

6.47.1 the notes of the meeting (file D, pages 13-14), and

6.47.2 the letter conveying the outcome of the meeting (file D, page 20).

6.48 The panel decided that the audit did not meet the criteria for a clinical audit of dispensing services. The letter stated (file D, page 20):

6.48.1 We were of the view that the repeat medication ordering process relates to the prescribing of medication and that non-dispensing practices will have similar processes. Given that the GMS contract, clause 1.1, defines “dispensing services” as:

6.48.1.1 “the provision of drugs, medicines or appliances that may be provided as pharmaceutical services by a medical practitioner in accordance with arrangements made under … the pharmaceutical regulations”

6.48.2 we were agreed that the subject matter of the audit was not part of the dispensing service, notwithstanding that the function happens to be being carried out by staff working in the dispensary.

6.49 This decision was informally conveyed, in brief, to the Practice’s representative by the Contract Manager (Pharmacy) by telephone later on 24 May 2019 and the letter formally setting out the outcome of the LDR meeting was sent to the Practice on 28 May 2019.

NHS England’s representations

6.50 NHS England considers that it has given the practice a full and fair opportunity to dispute the original decision.

6.51 Having considered the Practice’s written and oral representations made as part of local dispute resolution, we remain of the view that we made the correct decision in concluding that the audit did not meet the criteria for clinical audits of dispensing services, and therefore that the Practice had not met the entitlement conditions for the 2017/18 DSQS payment.

6.52 Not all practices delivering services under a GMS Contract are a dispensing practice and so, given the whole purpose of the DSQS is to assess and reward practices for providing high quality dispensing services, the very clear emphasis of the audit required by Annex H to the SFE is on the dispensing service. Prescribing services, such as the mechanism by which patients request repeat prescriptions, are not caught by the DSQS.

6.53 On a review of the Practice’s DSQS audit submission for 2017/18, it is clear that it concerns a ‘prescribing service’ and not a ‘dispensing service’ for the reasons articulated above.

6.54 NHS England is contractually obliged by virtue of the payment terms in the GMS Contract to make payment in accordance with the terms of the Contract and any directions given by the Secretary of State under s87 NHS Act 2006 (i.e. the SFE).

6.55 Accordingly, NHS England is contractually (and statutorily) obliged to only make the annual Dispensary Services Quality Payment where a contractor meets the requirements of the SFE (including as to the clinical audit required by Annex H).
Given a contractor’s entitlement to an annual Dispensary Services Quality Payment depends on them satisfying the various requirements set out in the SFE. NHS England is entitled under paragraph 25.1 of the SFE to recover an amount equivalent to the monies paid ‘on account’ given the Practice’s failure to satisfy the Eligibility Conditions.

To minimise the impact on the Practice, NHS England has agreed to recover the overpayment by virtue of deductions across 12 months. However, the Practice was on notice (see NHS England’s Bulletin of 6 April 2018) that payments were being made ‘on account’ and were subject to recovery. Accordingly, it is reasonable to have expected practices to have ring-fenced the monies in the knowledge they were potentially subject to clawback and, prior to closing their accounts, to have made enquiries of NHS England if they had not heard anything further in relation to their 2017/18 DSQS submission, rather than assuming otherwise. There is no deadline in the SFE by which NHS England must communicate any decision regarding a practice’s compliance with the conditions attached to a Dispensary Services Quality Payment and its entitlement to claw-back monies paid on account.

In view of the above, NHS England asks NHS Resolution to determine that:

6.58.1 the audit submitted by the Practice in relation to 2017/18 was not a clinical audit of dispensing services;

6.58.2 the Practice therefore did not comply with the Eligibility Conditions attached to the 2017/18 DSQS payment; and so given the Practice did not meet the Eligibility Conditions, NHS England is entitled to recover the sum of £9,956.22, being the amount paid to the Practice ‘on account’ in April 2018, from the Practice as an overpayment pursuant to paragraph 25.1 of the SFE.

Finally, we note that this appeal raises similar issues as two other appeals that are currently with the PCA (references: SHA/22143 and SHA/22144). Accordingly, in the interests of consistency of decision-making, we consider it would be helpful to have the three appeals considered together by the same adjudicator.

7. **NHS ENGLAND’S OBSERVATIONS**

By letter dated 23 August 2019 NHS England submitted its observations, which stated:

7.1 These are NHS England and NHS Improvement’s observations on the representations made to Primary Care Appeals by VWV solicitors on behalf of North Curry Health Centre ("the Practice"). For ease and to remain consistent with our representations dated 20 August 2019, we refer to NHS England and NHS Improvement throughout these observations as “NHS England”.

**Definition of dispensing services**

7.2 At several points within the Practice’s representations (see paragraphs 4.9, 7.2 and 7.4, [5.20, 5.33 and 5.34] for example) it is stated that the specification for the Dispensary Services Quality Scheme ("the DSQS") does not contain a definition of ‘dispensing services’.

7.3 However, that is not correct.

7.4 The DSQS framework is set out in the General Medical Services Statement of Financial Entitlements Directions 2013 ("the SFE", a copy of which was provided with the application for dispute resolution), which are made under s87 of the NHS Act 2006. Part 2 of Annex A to the SFE provides that “Unless the context otherwise requires, words and expressions used in this SFE and the 2004 Regulations bear the meaning they bear in the 2004 Regulations”. The 2004 Regulations have been repealed and replaced by the NHS (General Medical Services Contracts) Regulations 2015 ("the 2015 Regulations", see copy enclosed) and so reference to the 2004 Regulations...
should be construed as reference to the 2015 Regulations. ‘Dispensing services’ are defined in Regulation 3 of the 2015 Regulations (as they were defined in the 2004 Regulations) as:

7.4.1 “…the provision of drugs, medicines or appliances that may be provided as pharmaceutical services by a medical practitioner…” (emphasis added)

7.5 This definition is also incorporated into the terms of the Practice’s GMS Contract at clause 1.

7.6 ‘Dispensing services’ is therefore clearly defined as the provision of drugs, etc, to patients. For this and the other reasons we have set out in our representations, the scope of a ‘dispensing service’ does not cover the prescribing of drugs and medicines, or the handling of requests from patients for a prescription, which are activities that can be carried out by prescribing practices who are not also a dispensing practice. For example, a prescriber enables a person to obtain pharmaceutical services (such as drugs) but does not actually provide those services (which are carried out by a dispenser).

Dispensing process/service

7.7 In paragraph 4.10 [5.21] of its representations, the Practice attempts to find issue with NHS England’s original decision of 2 January 2019 by drawing a distinction between the concept of a ‘dispensing process’ and a ‘dispensing service’.

7.8 Insofar as there might be such a distinction, we would submit that ‘dispensing services’ are made up of various ‘dispensing processes’ such as assembling the medication, labelling, checking, and so on. However, this does not alter the key issue with the Practice’s audit which was that it was not concerned with a dispensing service (i.e. the provision of drugs, etc) at all, but with prescribing or even the stage before prescribing.

7.9 At paragraph 4.11 [5.22], the Practice asserts that ‘taking the repeat prescription orders is a key role of the dispensary’. However, as we have previously observed, just because the Practice is choosing to use dispensary staff to carry out this function does not make it part of the dispensing service. In a non-dispensing practice this function would be carried out by administrative staff, in many cases called ‘prescription clerks’. It is a function which is carried out before any prescription is issued, so cannot form part of the dispensing service.

7.10 The Practice suggests that it was reasonable to have interpreted the requirement to undertake a clinical audit of “dispensing services” as meaning an audit of the services carried out by its dispensary and by its dispensary staff. However, we do not agree that that interpretation was a reasonable one, in particular given the guidance issued to practices by NHS England which made clear that, as a general rule of thumb, if the audit could be undertaken by a non-dispensing practice then it probably is not a dispensing service. NHS England would have expected the Practice to have considered whether the audit topic of choice was sufficient having regard to the published guidance.

7.11 In this respect, we also note that the Practice suggests at paragraph 4.11 [5.22] of its representations that NHS England’s decision was based on an opinion in an article of the Dispensing Doctors’ Association (“DDA”) website. However, this statement demonstrates a misunderstanding of NHS England’s decision and the DSQS generally. First, the article on the DDA website is dated 27 February 2018, and therefore post-dates NHS England’s guidance sent to the Practice with the letter of 18 July 2017. Second, NHS England did not place any reliance on the wording on the DDA’s website in its original decision of 2 January 2019. Further, in referring to the DDA’s guidance in the oral representations at the Local Dispute Resolution meeting, NHS England was simply pointing to evidence from within the sector which reconfirms the principle already contained in NHS England’s guidance regarding the general rule of thumb.
Audit undertaken by North Curry Health Centre in 2006/07

7.12 At paragraphs 4.8 and 4.13.4 [5.19 and 5.26.4], the Practice refers to an audit which it submitted as part of the DSQS in 2006/07.

7.13 2006/07 was the year that small Primary Care Trusts merged into larger PCTs: the Practice’s relevant Primary Care Trust was Taunton Deane Primary Care Trust up to 30 September 2006 and Somerset Primary Care Trust from 1 October 2006. As the adjudicator will be aware, Primary Care Trusts were abolished and NHS England was established in April 2013.

7.14 NHS England does not have readily available to it any records relating to the DSQS 2006/07 and cannot therefore verify what the Practice says as regards the audit it carried out in 2006/07.

7.15 However we would make the following general observations on this point:

7.15.1 2006/07 was the first year of the DSQS; it is reasonable that the way in which the scheme is interpreted and applied will have matured over the subsequent 11 years as NHS England refined its processes. Over successive years commissioners have identified both good practice and also issues which they regard as not acceptable, and circulated guidance to contractors highlighting these.

7.15.2 The guidance to practices on carrying out clinical audits which was issued with our letter of 18 July 2017 (included in file A, pages 55-59) was originally developed by NHS England BNSSSG area team; we are not aware that such guidance was issued by the former PCT to practices participating in DSQS in 2006/07. Therefore the Practice should have taken account of NHS England’s guidance rather than assuming that an audit conducted before that guidance was produced would still be acceptable. This is particularly so given the Practice’s contractual obligation, at clause 499 of its GMS Contract, to have regard to all relevant guidance issued by NHS England.

7.16 The Practice attempts to place some reliance (at paragraph 4.7 of its representations) on the fact that it has never received negative feedback from NHS England (or the PCT) in relation to previous audits. We are not clear what the Practice thinks this shows, but we would simply clarify that since 2013 (i.e. when NHS England was established) the Practice’s audits have all been deemed acceptable and so did not warrant any negative feedback. We cannot comment in relation to its earlier audits for the reasons above.

Audits carried out by other practices in 2017/18

7.17 At paragraph 4.12.2 [5.24.2] the Practice refer to an audit carried out by another practice in the same year (2017/18) which they say related to the same audit topic as the Practice’s. We would observe that, in preparing their representations, the Practice has solely relied on the audit title given it has not seen the content of the audit itself.

7.18 However, that audit was a borderline one and was initially assessed as either ‘doubtful’ or ‘non-compliant’. The final assessment outcome was that, although the audit remained a borderline one, the practice had framed its audit in terms of patient safety benefits and so the practice concerned was given the ‘benefit of the doubt’ and the DSQS payment was not recovered.

7.19 It is NHS England’s position that, although it aims to act consistently, NHS England must nevertheless assess each practice’s audit on its particular merits.

Audits carried out by other practices in previous years
First, NHS England does not consider that it is reasonable nor appropriate to seek to rely on the titles of historic audits carried out by other practices in the way the Practice does for a number of reasons, including:

7.20.1 one cannot take the audit titles in isolation as the content of each audit: its objective and outcomes etc are what matter in terms of NHS England’s assessment;

7.20.2 we do not consider it would be appropriate for NHS England to be bound by previous decisions in relation to audits by other practices which, although on their face may appear similar, require a particular outcome based on their merits;

7.20.3 (as above) although NHS England aims to act consistently, it must nevertheless assess each practice’s audit on its particular merits;

7.20.4 NHS England must be allowed to develop and refine its processes over the years as it learns through experience; and

7.20.5 NHS England’s decisions in relation to historic audits by other practices is not something that is generally available to the public and so the Practice cannot argue that they have relied on past decisions when selecting their audit topic for 2017/18. We would highlight that the Practice has come into possession of these lists of titles of historic audits through Freedom of Information requests which it has submitted since the local dispute resolution meeting held on 24 May 2019.

Notwithstanding our comments above, we now address the historic audit titles referred to in the Practice’s representations.

Regarding the two audit titles from 2015/16 referred to at paragraph 4.13.1 [5.26.1] of the Practice’s representations), we would draw the adjudicator’s attention to the fact that both entries on page 54 of the Practice’s exhibit have a blank cell next to them – there is no indication that these topics have been ‘deemed acceptable’. As is stated at the top of that table (page 50 of the practice’s exhibit) NHS England’s assessment of DSQS evidence could not be completed in 2015/16: no assessment was made of the acceptability of these audits. So as to avoid any unfairness to practices due to this, no DSQS payments were recovered in that year.

Regarding the two audit titles from 2014/15 referred to at paragraph 4.13.2 [5.26.2] of the Practice’s submission, we would highlight the statements on pages 44 and 45 that the DSQS assessment did not include a detailed review of the audits.

Other practices being able to submit alternative audits

In paragraph 4.13.5 [5.26.5] the Practice states “We also note that in 2017/18 two practices were invited to submit replacement audits after the Commissioner did not approve their first submission”. This is also referred to at paragraph 6.2.3 [5.31.3], with the added comment that “some Contractors are treated more favourably than others”. 

23
That statement is based on an incorrect assumption. NHS England did not invite any practices whose 2017/18 DSQS audits were not approved to submit alternative audits. All practices who disputed NHS England’s decision received the same response as the Practice, as follows (see email on page 16 of file A):

To proceed with the dispute resolution process, please submit to us your supporting evidence in relation to this matter.

Some practices chose, of their own volition, to submit an alternative audit which had been carried out during 2017/18 as part of their evidence. In some cases, the practice contacted NHS England to ask if they could submit an alternative audit, in which case they were informed that they could submit whatever they wished as evidence for the local dispute resolution process. In those cases where an alternative audit was submitted, NHS England considered that alternative audit as part of the local dispute resolution process.

In North Curry’s case, the Practice neither contacted NHS England to discuss submitting an alternative audit nor submitted one. Therefore it is not a case of other contractors being treated more favourably than North Curry, but rather that other contractors more actively engaged with the local dispute resolution procedure with a view to resolving matters amicably between the parties.


Finally, we want to reiterate that participation in the DSQS is voluntary and that not all practices who are authorised to provide dispensing services under their GMS contract are members of the scheme. Therefore, the additional Dispensary Services Quality Payment (which sits on top of the practice’s annual GMS payments) is an additional benefit to practices who have opted to participate in the scheme and have therefore agreed to comply with all of its requirements to NHS England’s satisfaction.

NHS England remains of the view that we made the correct decision when we concluded that the audit did not meet the criteria for clinical audits of dispensing services, and therefore that the Practice had not met the eligibility conditions for payment of the 2017/18 DSQS monies.

NHS England therefore asks NHS Resolution to determine that:

7.33.1 the audit submitted by the Practice was not a clinical audit of dispensing services,

7.33.2 the Practice therefore did not comply with the eligibility conditions for payment of the 2017/18 DSQS payment, and so

7.33.3 NHS England is entitled to recover the sum of £9,956.22, being the amount paid to the Practice ‘on account’ in April 2018, from the Practice as an overpayment, pursuant to paragraph 25.1 of the SFE.

8. CONTRACTOR’S OBSERVATIONS

By letter dated 3 September 2019 the Contractor submitted its observations, which stated:

8.1 This is the second submission of Dr James Hickman MBE and Dr Nicholas Chapman (the second submission), the partners of North Curry Health Centre of Greenway,
North Curry, Taunton, Somerset, TA3 5NQ made pursuant to NHS Resolution’s invitation in its letter dated 22 August 2019.

8.2 The content of the first submission is repeated and we will be only be dealing with the points raised by NHS England in this second submission. We are having to reply in general terms, rather than specific paragraphs, as NHS England’s first submission does not contain numbered paragraphs and points are repeated throughout it. Where possible, we will refer to page numbers in the NHS England submission.

8.3 In its first submission, NHS England quote a guidance note (at the bottom of page 4 and top of page 5) which advised dispensing practices on what audit topics would not be accepted.

8.4 NHS England considered that the contractor’s audit did not meet “the requirements for a clinical audit of dispensing services.” We wish to repeat the rebuttal of this point that we made in our first submission in paragraph 4.5 [5.15] on page 3:

8.5 “The topic selected concerned the ordering of prescriptions by telephone. The audit collated information to establish why patients chose to telephone the dispensary to order medication and why those patients were not using Patient Access or an alternative method of ordering.

8.6 Amongst other things, the audit’s intention was to:

8.6.1 improve stock management by the dispensary by increasing use of Patient Access;

8.6.2 reduce the risk of dispensing errors;

8.6.3 improve the service provided to patients and their experience;

8.6.4 ascertain why patients contact the dispensary by telephone to order their prescriptions, rather than by Patient Access accessed via the EMIS online portal, which is the Practice’s preference in accordance with NHS guidelines;

8.6.5 identify any possible barriers preventing patients from using Patient Access, a more efficient and safer method of ordering prescriptions than by telephone, and in so doing identifying solutions; and

8.6.6 promoting knowledge of and the use of Patient Access amongst patients, to improve risk management.”

8.7 These were the reasons why this audit could not have been done, and the same benefit derived, from it by a non-dispensing practice.

8.8 In addition, in paragraph 4.11 [5.22], page 4, of our first submission we stated that:

8.9 “Furthermore, the Commissioner indicated that its decision to fail the Contractor’s audit was based on an opinion in a journalist’s article on the DDA’s website Appendix 4 (pages 40 to 42 of the exhibit). The article states that:

8.10 “The audit is an audit of dispensing processes (including advice given by dispensary staff to patients) and NOT prescribing or other related activities. The general rule of thumb used by the AT will be that if the audit could be undertaken by a non-dispensing practice it is not a dispensing audit”.

8.11 The article is not part of the agreed DSQS specification and fails to acknowledge that a dispensing and a non-dispensing practice could undertake an audit on the same topic
but the purpose, value and the learning from the audit will be very different for those two practices.

8.12 In the Contractor's practice, taking the repeat prescription orders is a key role of the dispensary because amongst other things the dispensary is able to offer advice to patients at an early stage (where appropriate), raise issues with doctors before the prescribing stage and manage their stocks of medicines safely.

8.13 This highlights that the guidance referred to in NHS England’s first submission was not part of the DSQS specification.

8.14 Furthermore, in paragraphs 4.12 - 4.14 [5.24 – 5.27], pages 4-5, of our first submission we stated that:

8.14.1 “For the avoidance of any doubt, enclosed at Appendix 5 (pages 43 to 63 of the exhibit) is a spreadsheet of audit topics submitted to NHSE in the South West of England in completion of the DSQS between 2013 / 2014 and 2018 / 2019. This information was obtained through a Freedom of Information Act request.

8.15 The Contractor's audit topic for the Service Period was "Phone - Ordering of Prescriptions".

8.16 This was rejected by the letter dated 2 January 2019.

8.17 In 2017-2018 an audit from another practice that was accepted was titled (page 59 of the exhibit):

8.17.1 “This audit will look at how patients are currently ordering their medication with a view to promoting the use of online access in line with NHS guidance. Auditing the repeat prescription process will identify interruptions during the dispensing process, promoting alternative ways of ordering repeat medication will potentially reduce the risk of dispensing errors” [sic]."

8.18 The audit referred to in paragraph 4.12.2 [5.24.2] was accepted. It does clearly explain the purpose of the audit and how it will benefit patients. It was written in a more expansive and explanatory matter than that of the Contractor but it is clearly in respect of the same thing (manner of taking repeat prescription orders in the dispensary) and had the same intention and goal as that of the Contractor. However, the Contractor's audit on the same topic was rejected. The Contractor attempted to explain the purpose within their audit, highlighting the fact that ordering repeat prescriptions on the internet was an accurate, safe and preferred approach but ultimately a problem for a practice with a significant elderly population, meaning the practice would need to continue engaging with those patients and promoting electronic ordering. The Commissioner should have discussed the Contractor's audit with them to better understand it.

8.19 Other items of note on the spread sheet at Appendix 5 include:

8.20 In 2015/2016 the following audits were deemed acceptable (page 54 of the exhibit):

8.20.1 "To make the process of obtaining repeat prescriptions by our rural dispensing patients easier. Evening out work load. Reducing need of patients having to travel to the surgery twice monthly thus reducing fuel."

8.20.2 "We have recently experimented with taking requests for repeats when patient collects their medication. This is getting very positive responses from patients who like the service as it proving much more efficient with less Owings and improved workflow. Patients do not then have to make a separate visit to deposit their next request and dispensers can control their workflow. It is proving efficient over times of bank holidays. We are undertaking a
questionnaire regarding this new service both to get any feedback and to raise awareness of those who have not seen it yet."

8.21 In 2014 / 2015 the following audit titles / topics were deemed acceptable (page 48 of the exhibit):

8.21.1 "Repeat Prescription Audit"

8.21.2 "Repeat prescription ordering"

8.22 In 2013 / 2014 the following audit titles / topics were deemed acceptable (pages 45 and 46 of the exhibit):

8.22.1 "An audit focussing on the process from ordering – whether by phone, fax, email, website, post, online access or in person to completion and collection. How we can improve our services thus making the process of ordering medication as quickly, conveniently, accurately and efficiently as possible."

8.22.2 "Repeat dispensing"

8.23 The Contractor also filed an audit in 2006/7 on the dispensary taking repeat prescription orders (the same audit area as in 2018). The 2007 audit was accepted by the Commissioner in 2007 yet the same audit topic was failed by the same NHS employee in 2018.

8.24 We also note that in 2017 / 2018 two practices were invited to submit replacement audits after the Commissioner did not approve their first submission (page 60 of the exhibit). Their replacement audits were accepted. The Contractor was not provided with any opportunity to provide an alternative audit for 2017 / 2018 unlike those two practices. This further demonstrates inconsistency in the approach taken to the other practices. All practices which had their audit topic rejected should have had the opportunity to submit a replacement audit.

8.25 In 2018 / 2019 eight practices were invited to submit replacement audits after the Commissioner did not approve their first submission (page 62 of the exhibit). Their replacement audits were accepted. Again, in the interests of fairness, all practices which had their audit topic rejected should have had the opportunity to submit a replacement audit.

8.26 The audit assessment criteria are not transparent. A review of the audit titles and whether or not they passed or failed does not reveal the logic or criteria applied by the Commissioner when deciding whether an audit has passed. Providing more transparent explanation of the logic and criteria used to pass or fail an audit would leave the issue less open to confusion and interpretation and reduce the risk of a practice successfully providing the services for a year but not getting reimbursed fully for that due to a technicality or difference of interpretation."

8.27 NHS England’s first submission states that: “...there is no obligation on NHS England to allow practices to revise and re-submit evidence that is considered to be non-compliant.” If this is so, then paragraphs 4.12 - 4.14 [5.24 – 5.27] of our first submission highlight the lack of consistency in NHS England’s approach. Some practices were invited to re-submit, or clarify, audits where NHS England had questions, and another practice appears to have submitted exactly the same audit as the Drs Hickman and Chapman and passed, but simply provided more expansive wording.

8.28 We disagree with the assertions made at the top of page 8 of NHS England’s submission.
8.29 We would refer, again, to paragraph 4.5 [5.15] of our first submission, quoted above, which clearly explains the ways in which the audit benefitted Drs Hickman and Chapman’s practice when compared to a non-dispensing practice.

8.30 NHS England argue that: “...it is the duty of the prescriber to ensure they are prescribing the correct medications...” The audit could only have been done by a dispensing practice, because its specific purpose is to ensure the appropriate stock levels can be properly managed in a rural practice with an elderly, and less mobile, patient list, in order to ensure that there is no delay in the dispensing of repeat prescriptions.

8.31 In conclusion, we request that NHS Resolution make the determinations made at paragraph 8 [5.37 – 5.38], pages 7 and 8, of our first submission.

9. DETERMINATION

9.1 I have reviewed the Application, the Representations and the Observations made by the parties. I am grateful to the parties for their detailed submissions.

9.2 I note that there is no dispute that the Contractor signed up to participate in the Dispensary Services Quality Scheme 2017/2018 (“DSQS”).

9.3 I have noted a copy of Section 24, Section 25 and Annex H of the General Medical Services Statement of Financial Entitlements Directions 2013 (“SFE”) and a copy of the ‘Dispensary Services Quality Scheme Supplementary guidance for revisions to the GMS contract 2006/07” (“the Guidance”) as produced by the BMA and NHS Employers, provided to me by NHS England. I note that the Contractor has also provided a copy of the Guidance and has not disputed the SFE provided, against which the DSQS was considered and I will therefore proceed on this basis.

9.4 I note that the issue is NHS England’s decision to recover the monies paid to the Contractor for participation in the DSQS. I note that the recovery of the monies stems from NHS England’s decision that the clinical audit submitted by the Contractor does not meet the criteria for a clinical audit of dispensing services. As the decision to recover the monies is linked to the acceptability of the clinical audit submitted by the Contractor I shall first consider the parties’ submissions in relation to whether the clinical audit met the criteria for clinical audits of dispensing services.

9.5 I note that the Contractor’s audit is undated but was conducted between 1 and 28 February 2018. I note there is no dispute that the Contractor’s audit was submitted to NHS England within the allocated timeframe. I note that NHS England submits that the audit does not meet the criteria for a clinical audit of dispensing services and therefore the Contractor had not met the entitlement conditions for the DSQS payment.

9.6 I note that the audit report states that the reason for performing the audit was “to establish how many patients phoned the dispensary to order their prescriptions and to assess if they were aware of Patient Access that allows them to order electronically via EMIS Web.”. In its representations the Contractor states that the topic of the audit was “to establish why patients chose to telephone the dispensary to order medication and why those patients were not using Patient Access or an alternative method of ordering”.

9.7 The Contractor also states that the audit’s intention was to “improve stock management”, “reduce the risk of dispensing errors”, “improve the service provided”, “ascertain why patients contact the dispensary by telephone”, “identify barriers preventing patients from using Patient Access” and “promoting knowledge and use of Patient Access.”

9.8 I note that there is no dispute as to the content of the minutes of the meeting 24 May 2019 as provided within NHS England’s representations.
I will therefore determine whether or not the audit met the criteria for clinical audits for dispensing services.

I shall first consider the criteria for clinical audits for dispensing services. I note that section 24 of the SFE includes the following:

“24.3. A contractor that has consent to dispense will be eligible for an annual Dispensary Services Quality Payment, calculated in accordance with the provisions of this Section, if—

(c) the Board is satisfied, following review of the contractor’s arrangements (which the Board is to undertake between 1st January and 31st March inclusive of the financial year to which the payment relates or, where the provision of the service terminates before 1st January for any reason, on such other date as the Board may, in consultation with the contractor, consider reasonable) that the contractor is providing the required level of service and is achieving the required standards, as set out in Annex H. This eligibility condition will only be satisfied if the contractor—

(i) complies with any reasonable requirement imposed on it, as part of that review, to provide documentary evidence of matters the Board needs to consider in order to satisfy itself as to compliance with the standards and levels of service set out in Annex H;”

I consider that the Contractor’s eligibility for the DSQS payment is subject to the achievement of the standards set out in Annex H of the SFE and the Contractor complying with “any reasonable requirement imposed on it” by NHS England to provide the evidence that it needs to satisfy itself that the Contractor has achieved the standards set out in Annex H.

I note under the heading ‘SOPs, clinical audit and risk management’, Annex H.1.3 states:

“The contractor must participate in contractor lead clinical audit of dispensing services. Clinical audit seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change. Audit of dispensing services should include arrangements to assess the nature and quality of the advice provided to patients as part of the dispensing service.”

I note the Guidance further states that:

“Practices will wish to ensure that clinical audit programmes include the dispensing systems and assess the nature and quality of information given to patients by the staff dispensing in the practice, to help patients get the best from their prescribed medicines. It is recommended that the learning from these audits is shared with all practice staff, not only within the dispensary.

It is recommended that clinical audit programmes also use the information that the dispensary may provide to contribute to audits of other parts of the practice’s services e.g. patient information, records, critical incidents.”

In my view the SFE and the supporting Guidance makes clear that, in order to qualify for payment, the Contractor needs to have carried out an audit of dispensing services.

I have had regard to the audit. I note that the audit is in relation to the ordering of prescriptions by phone. I understand that the subject matter of the audit is not an issue in dispute.

The audit contains the following headings:
9.16.1 Phone – Ordering of Prescriptions

9.16.2 Reason for performing the audit

9.16.3 Criterion

9.16.4 Standard

9.16.5 Method

9.16.6 Results of audit

9.16.7 Discussion

9.16.8 Recommendations

9.17 The section on “Phone – Ordering of Prescriptions” explains that “The Audit collated information to establish why patients chose to order medication by telephone and why the patients were not using Patient Access or an alternative method of ordering.” I consider that this section is useful background information as an explanation of the subject matter of the audit.

9.18 The section on “Reasons for performing the audit” states: “to establish how many patients phoned the dispensary to order their prescriptions and to assess if they were aware of Patients Access that allows them to order electronically via EMIS Web.” I consider that this section is an extension of the background information focussing in more detail on the types of data that the audit was intended to provide.

9.19 The section on “Criterion” states “Repeat prescription requests should be by Patient Access as much as possible. This forms part of the risk managements in the dispensary.” I consider that this section continues the explanation of the background by stating the Contractor’s preferred method for patient requests for repeat prescriptions and a reference that this ties in with risk management. I note that the reference to risk management here is limited.

9.20 The section on “Standard” states “90% of patients order prescriptions by Patient Access or by one of the surgery’s other preferred methods.” I consider that this section also provides background information that relates to the subject matter of the audit.

9.21 The section on “Method” sets out the information which the dispensers record, including “Date, Patient EMIS number, Patient age, Access to a computer / internet, Know about Patient Access, Register for Patient Access, If registered for Patient Access what would encourage them to use it, Why had the patient rung today and Notes / Problems.” I note that this section contains the information the Dispensary staff ask of each telephone caller.

9.22 The section on “Results of audit” states “the dispensary received 124 calls for repeat prescription requests via the prescription telephone line and 610 via Patient Access.” I note the results provide a breakdown of information about patients who requested via the telephone including: the number of patients who had no access to the internet or a computer, knew about Patient Access, said they would register or re-register, who said nothing would encourage them to use the internet and those experiencing problems with Patient Access. Other figures included the percentage of patients who rang on behalf of others, would like some instruction, preferred to talk to someone in person, EMIS Access had stated they should contact the surgery if ordering items other than repeats, no time to being in ID to register, rang for other / item not on repeat etc. 65 years and over. I consider that this section demonstrates how telephone prescription orders were taken.
9.23 The section on “Discussion” states “North Curry has an elderly population and this is a contributing factor to the number of patients who ring for their prescriptions. 51.61% of the patients who rang were over 65, not all of whom are familiar with technology and online ordering. Some patients are not keen or have no access to a computer, internet or smart phone. Others liked human contact and just wanted to talk to someone. Patients are experiencing problems with Patient Access locking them out and forgetting passwords. If these issues could be resolved than [sic] perhaps patients would be willing to register again but when this keeps happening patients understandably have not got a positive view of Patient Access and are unwilling to keep trying. Some orders are placed by family members or others on their behalf and they are unable to do this via Patient Access due to confidentiality. Patients who do not use Patient Access regularly are being locked out because they cannot remember their passwords. We found that this is a frequent occurrence with patients ordering the contraceptive pill every three months.” I consider that this section is essentially an analysis of the responses to the questions asked of those patients requesting repeat prescriptions.

9.24 The section “Recommendations” states “The surgery will continue to encourage patients to use either Patient Access or any other method other than phone to request prescriptions. When new patients register the reception staff will inform them about Patient Access, as this is an ideal time as patients need their ID to register. The surgery will produce a power point presentation informing patients of Patient Access and other preferred methods of ordering medication and this will run in the waiting room. The dispensary will ask patients if they are aware of Patient Access if they are taking a telephone request for medication. The audit will be re-run in 6 months.” I consider that this section sets out how the Contractor will encourage patient uptake of the Patient Access system as opposed to ordering prescriptions over the telephone.

9.25 I am of the view that the audit is focussed on:

9.25.1 the Contractor understanding why some patients order repeat prescriptions via telephone rather than the Contractor’s preferred method – using the online Patient Access; and

9.25.2 the actions the Contractor will take as a result of the findings to encourage more patients to use Patient Access.

9.26 The dispute between the parties is whether this amounts to a clinical audit of dispensing services for the purposes of the DSQS. The parties each provide arguments in support of their opposite views on this point. I consider those arguments below.

9.27 The Contractor indicates that the specification for the DSQS set out in the Guidance allows the Contractor to decide the topic of the audit. There is no dispute about this but I would note that it is for the Contractor to ensure that the topic chosen relates to dispensing services as that is the clear intention in the SFE and Guidance. I note that the Contractor states here that "the Contractor must decide the subject matter of the audit to reflect upon the dispensary services provided…". I note the reference here by the Contractor to “dispensary services” which in my mind could be different from “dispensing services”. The former could be any service provided by or in a dispensary – it need not be related to dispensing at all. The latter clearly must link to dispensing. I consider further what this term means later in this determination.

9.28 The Contractor indicates that it selected a topic that is performed at its dispensary which was “appropriate and beneficial for its dispensary with a view to the need to improve patient care and outcomes”. It is not clear from the wording of the audit that the stated intention of the audit - understanding why some patients don’t use Patient Access to request repeat prescriptions - improves patient care and outcomes.

9.29 The Contractor states that the audit's intentions were to improve stock management, reduce risk of dispensing errors, improve service to patients, identify barriers to using Patient Access (indicated by the Contractor in its representations as a “more efficient
and safer method’), and improve risk management by promoting use of Patient Access. In response, NHS England indicates that it is not clear what risk(s) the audit was intended to address. NHS England notes this is not something that was addressed in the audit itself, nor was it further clarified in the Contractor’s dispute letter.

9.30 In my view the audit only expressly refers, as an intention of the audit, to identifying barriers to using Patient Access. The audit refers to use of Patient Access forming “part of the risk managements in the dispensary” but this reference does not provide any further detail on what risks use of Patient Access manages or how. There is no reference in the audit to stock management, dispensing errors or service provision to patients. There was also no reference to intentions relating to stock management or dispensing errors in the notes of the dispute resolution meeting held in May 2019. The Contractor’s note of that meeting states that the reason for the audit was to reduce risks in the dispensary and that the aim of the audit was to identify the method and reason why some patients are not using the safest options for repeat medication requests but in my mind this does not equate to being clear about any consequential impacts on stock management or dispensing errors.

9.31 The paragraphs above relates to certain arguments put forward by the parties but in my opinion they do not address the substantive issue, which is whether the audit carried out by the Contractor was an audit of dispensing services. I go on to consider these arguments below.

9.32 The Contractor notes that there is no definition of dispensing services in the Guidance. It indicates that it reasonably interprets the term “dispensing services” to mean services carried out in its dispensary and by its dispensary staff in the performance of their dispensary duties.

9.33 NHS England argues that the reference to dispensing services is used in the SFE which also states that Part 2 of Annex A to the SFE indicates that unless the context otherwise requires, words and expressions used in the SFE bear the meaning they bear in the NHS (General Medical Services Contracts) Regulations 2004. NHS England goes on to indicate that the NHS (General Medical Services Contracts) Regulations 2015 which replaced the 2004 Regulations defines dispensing services in Regulation 3 as:

“…the provision of drugs, medicines or appliances that may be provided as pharmaceutical services by a medical practitioner…”

9.34 I note that the Contractor does not respond on this point. I therefore consider that the term “dispensing services” in the context of the DSQS should be read in line with the definition in the Regulations as set out above.

9.35 In respect of the Contractor’s indication that it reasonably interprets the term “dispensing services” to mean services carried out in its dispensary and by its dispensary staff in the performance of their dispensary duties, NHS England indicates that the Practice is choosing to use dispensing staff to receive and process requests for repeat medication. NHS England states that this does not have to be done by dispensing staff and just because the Contractor is choosing to use dispensary staff to carry out this function does not make it part of the dispensing service. In a non-dispensing practice this function would be carried out by administrative staff, in many cases called ‘prescription clerks’.

9.36 I agree with NHS England to the extent that certain staff doing an activity in a certain part of the GP practice does not automatically mean that activity must be of a certain type. Instead it is the nature of the activity that matters and not who carries it out or where it is carried out.

9.37 Before going on to consider the comments made in relation to whether a non-dispensing practice could carry out the activity that is the subject matter of the audit, I would refer to the Contractor’s references to NHS England rejecting the audit on the
basis that the audit was not about a dispensing “process”, that this was not part of the Guidance and that NHS England had indicated that it based its decision on a news report on Dispensing Doctors’ Association website.

9.38 NHS England responds by stating that the article on the DDA website is dated 27 February 2018 and therefore post-dates NHS England’s guidance sent to the Contractor on 18 July 2017. NHS England goes on to say that it did not place any reliance on the wording on the DDA’s website in its original decision of 2 January 2019 and that reference to the DDA’s guidance at the local dispute resolution meeting in May 2019 was simply NHS England pointing to evidence from within the sector which reconfirms the principle already contained in NHS England’s guidance regarding the general rule of thumb.

9.39 I note that the reference by NHS England above are not to the substantive Guidance on DSQS. Instead the guidance referred to is the “good practice guidance” as referred to in the 18 July 2017 letter. NHS England considers that there is a contractual duty on the Contractor to have regard to such guidance. The Contractor does not respond to this point.

9.40 I agree that a Contractor must have regard to guidance but I do not consider that this means the Contractor must, as a contractual obligation, follow that guidance. The obligation to “have regard to” something is not as strong as “doing exactly what it says”.

9.41 I therefore find that NHS England has not based its decision on a news report on a website. I consider the point about dispensing process as opposed to dispensing services later in this determination.

9.42 I next consider the references to the “rule of thumb” set out in the guidance attached to NHS England’s letter dated 18 July 2017 which NHS England sent to the Contractor, namely that “if the audit could have been done equally well by a non-dispensing practice then it is probably not really about the dispensary”.

9.43 The Contractor states, in support of its view that the audit should be acceptable to NHS England, that the rule of thumb is not part of the agreed DSQS specification and fails to acknowledge that a dispensing and a non-dispensing practice could undertake an audit on the same topic but the purpose, value and the learning from the audit will be very different for those two practices. The Contractor goes on to state that in the Contractor’s practice, taking the repeat prescription orders is a key role of the dispensary because amongst other things the dispensary is able to offer advice to patients at an early stage (where appropriate), raise issues with doctors before the prescribing stage and manage their stocks of medicines safely.

9.44 In my view, the rule of thumb is contained in guidance issued to contractors and so the Contractor was required to have regard to it. It does not have the same force as an express contractual requirement. I therefore do not agree that if a non-dispensing practice could have done the activity that it is the subject of an audit then it is automatically not an audit relating to dispensing services and that this means there is non-compliance with the DSQS. I note that the rule of thumb itself uses the words “probably not really about the dispensary”. This leaves the door open to the possibility that there is activity that might be done by both dispensing and non-dispensing practices and at the same time is about dispensing services. In my mind, this is a factor to consider when considering whether the activity of the audit is about dispensing services.

9.45 On this point, the Contractor states that a non-dispensing practice couldn’t have done the audit and the same benefit derived. NHS England’s view is that all practices – whether dispensing or not – receive requests for repeat medication and need to ensure that these are handled efficiently and that the correct medication is prescribed.
9.46 The Contractor goes on to state that the audit could only have been done by a
dispensing practice because its specific purpose was to ensure the appropriate stock
levels can be properly managed in a rural practice with an elderly, and less mobile,
patient list, in order to ensure that there is no delay in the dispensing of repeat
prescriptions. As I have indicated above, I can see no reference, express or implied, in
the audit or the notes of the local dispute resolution meeting that refers to stock
management being an objective or intention of the audit.

9.47 As I have eluded to above, while the rule of thumb is a factor to consider when
assessing if an activity is a dispensing service, I do not consider that application of the
rule provides a final word on this. In my opinion, the most important factor in
determining whether an activity is a dispensing service is the nature of the activity itself.

9.48 I therefore turn to the complex issue of the meaning of dispensing services and whether
it can be said that the Contractor’s audit was of dispensing services.

9.49 Annex H of the SFE does not set out a template to complete or otherwise dictate the
content of the clinical audit. A template was provided with NHS England’s letter of 18
July 2017 and while this gives example of types of dispensing services audits, I cannot
see that this is an exhaustive list. I note that the ordering of prescriptions by telephone
which is the subject of the Contractor’s audit is not included in this list. I consider that,
while this may be a further factor in considering if the Contractor’s audit was an audit
of dispensing services, just because it does not appear in the list does not mean it is
automatically not a dispensing service audit. I consider that there is not a single
exhaustive list that contains all the possible subject matters for the clinical audit
element of the DSQS.

9.50 I note that the Guidance specifies what may be measured in a clinical audit of
dispensing services, for example, safety, accuracy or efficiency of dispensing or
associated processes, which, in my view provides a further pointer to the expected
content of the audit.

9.51 The Contractor, in its representations on this appeal, argues that the activity that was
the subject of the audit - taking the repeat prescription orders - is a key role of the
dispensary because amongst other things the dispensary is able to offer advice to
patients at an early stage (where appropriate), raise issues with doctors before the
prescribing stage and manage their stocks of medicines safely.

9.52 NHS England considers that it is the responsibility of the prescriber to ensure that the
correct medication is prescribed and that ensuring that the medication details are
correct is therefore part of the prescribing process.

9.53 NHS England points out that the Contractor, in the local dispute resolution meeting
notes refers to “the prescribing being performed at a later stage” (i.e. after the activity
that is the subject of the audit). NHS England says that:

9.53.1 very little, if any, of the dispensing process can come before the prescribing;
9.53.2 until the prescriber has issued the prescription there is nothing to dispense;
9.53.3 if the prescribing comes after the process covered by the audit, then the
process covered by the audit is not part of dispensing; and
9.53.4 prescribing services, such as the mechanism by which patients request repeat
prescriptions, are not caught by the DSQS.

9.54 It is NHS England’s view that a prescriber enables a person to obtain pharmaceutical
services (such as drugs) but does not actually provide those services (which are carried
out by a dispenser). NHS England puts this another way - prescribing is the process of
the patient requesting, and the prescriber authorising, the issue of medication whereas
dispensing is the process of providing the medication to the patient. NHS England completes this by saying that it is a function which is carried out before any prescription is issued so cannot form part of the dispensing service.

9.55 The Contractor, in its observations, does not agree with this and restates its previous comments on the intentions of the audit and that it was carried out in its dispensary and by its dispensary staff in the performance of their dispensary duties.

9.56 My view is that for the purpose of the DSQS, the starting point is to refer to the definition in the Regulations, i.e. that dispensing services relates to the provision of drugs, medicines or appliances that may be provided as pharmaceutical services by a medical practitioner. So it is “provision” of drugs that is relevant. There is clearly a spectrum of what provision of drugs means. At one end it could be argued to incorporate the whole process by which drugs are provided, i.e. a patient tells the GP what is wrong, the GP prescribes a drug, the GP issues a prescription and the patient receives the drug. If anyone of these parts is missing then there is no provision of drugs.

9.57 At the other end of the spectrum, provision of drugs could simply mean the physical receipt of the drugs to the patient – the very final stage.

9.58 Neither of these extreme views are very useful as:

9.58.1 the former clearly includes services that would reasonably be considered as prescribing services (as opposed to dispensing services); and

9.58.2 the latter doesn’t include services like preparing the drugs, checking the drugs, bagging up the drugs and labelling the drugs – all of which are usually considered to be dispensing services (as opposed to prescribing services).

9.59 I consider that the context in which this question is being asked is relevant. The DSQS is specifically aimed at practices that dispense drugs to patients. I therefore consider that a clinical audit of dispensing services in the context of the DSQS must relate to the dispensing services that the practice provides as part of its dispensing of drugs to patients.

9.60 The nature of the activity that is the subject of the audit carried out by the Contractor is repeat prescription requests. The Contractor expressly refers to the intention being to identify why some patients don’t use Patient Access to do this. My view is that an audit that identifies why patients use one method and not another for requesting repeat prescriptions does not relate to the dispensing services that the practice provides as part of its dispensing of drugs to patients.

9.61 I find NHS England’s arguments, as to the point in the prescribing/dispensing process at which this activity occurs, to be compelling. The Contractor expressly refers to prescribing happening after this activity. I agree with NHS England that the dispensing services carried out by a dispensing practice in the context of the DSQS relate to the activities after the prescribing stage and not before it.

9.62 I can appreciate that the Contractor could easily consider that an activity carried out by dispensing staff in the dispensary /dispensing service is likely to be a dispensing service but, as I have outlined above, I do not consider this to be the defining factor. I also do not consider that NHS England was focussed on accepting audits on the basis of "dispensing processes" as opposed to dispensing services. I am not of the view that there is a material difference in these terms for the purpose of the DSQS. I do not consider that dispensing services incorporates anything and everything that persons in a dispensary may do.

9.63 As the activity was not on the list of examples provided by NHS England in its guidance issued on 18 July 2017, I consider that it would have been prudent for the Contractor
to consider this point in detail and perhaps seek assurances that the planned subject matter was acceptable.

9.64 Having come to the conclusion above, it is necessary for me to consider related issues raised by the Contractor. These include that an audit by a different practice was considered by NHS England to relate to dispensing services (as well as audits in previous years) and that NHS England did not invite the Contractor to submit a second audit.

9.65 In relation to other audits, I note the Contractor has provided a spreadsheet of audit topics submitted to NHS England in the South West of England in completion of the DSQS between 2013/14 and 2018/19 as obtained through a freedom of information request.

9.66 I note under the 2013/14 heading the Contractor refers to two audits “An audit focusing on the process from ordering – whether by phone, fax, email, website, post, online access or in person to completion and collection” and “Repeat dispensing”. There is no “Approved” or “Internal review” box so I am of the view that it is not clear if these audits were acceptable or not.

9.67 I note under the 2014/15 heading there was an audit entitled “How patients request their medication with a view to limiting the phoned requests to Dispensary”. I note that the box entitled “Approved?” is marked “N”. Assuming “N” means no and “Y” means yes I have assumed that this indicates that this particular audit was not approved.

9.68 I note under the 2014/15 heading the Contractor refers to two further audits entitled “Repeat Prescription Audit” and “Repeat prescription ordering”. I note the Contractor states in its representations that these two audits were deemed acceptable. I note that the box entitled “Approved?” is marked “Y”. I am of the view that this indicates that these particular audits were approved.

9.68.1 I note under the 2015/16 heading there was an audit to “measure how many repeat medication requests we are receiving to be dispensed from each method; patient access (online), via post and via the telephone. The box entitled “Internal review” is marked with a “?”. I am of the view that it is not clear if this audit was approved or not.

9.68.2 I note under the 2015/16 heading the Contractor refers to an audit regarding “taking requests for repeats when patient collects their medication” and another audit regarding “To make the process of obtaining repeat prescriptions by our rural dispensing patients easier.” The box entitled “Internal review” is left blank. I note the Contractor is of the view that these audits were deemed acceptable. Having noted the box “Internal review” for all the listed audits either contains a “Y”, a “?” or is left blank. I consider that if left blank must indicate no review was required. I am of the view that these two audit were approved.

9.68.3 I note under 2016/17 heading there is an audit topic “reduce the number of telephone repeat prescription orders received into the Practice especially outside of telephone ordering times.” The box entitled “Internal review comments” states “not a dispensing audit.” I am of the view that this indicates that this particular audit was not approved.

9.68.4 I note under the 2017/18 heading there is an audit topic “Phone ordering of Prescriptions” and “Determining the most popular method used by patients to order repeat medication”. I note the in the box entitled “Accepted?” both of these audits are marked “N – no stated benefit to patients”. I am of the view that assuming “N” means No that these two audits were not approved.

9.68.5 I note under the 2017/18 heading the Contractor’s Representative refers to an audit regarding “how patients are currently ordering their medication with a
9.69 I note NHS England, in its observations, has stated that the practice has “solely relied on the audit title given it has not seen the content of the audit itself. ....... It is NHS England’s position that although it aims to act consistently, NHS England must nevertheless assess each practice’s audit on its particular merits.”

9.70 I have considered both parties comments regarding the previous audits. Whilst some of the audits as described above have been accepted, others have not. I do not have access to the full audit reports for each of these titles, therefore I am not in the position to be able to draw a fair comparison based on the title alone. In my view, the fact that some appear to have been accepted and some have not indicates that audits that may sound from the titles alone that they are similar to the Contractor’s audit are not automatically accepted as relating to dispensing services. Whether or not an audit was approved will likely depend upon the specifics of the content of the audit. I do not consider that it is enough to refer to a similarly sounding title of an audit that was accepted and claim that the Contractor’s audit must be the same and so must be accepted. This is especially the case where there are audits with similar titles that have not been accepted. I therefore agree with NHS England that each audit must be assessed on its own particular merits.

9.71 In relation to NHS England not inviting the Contractor to submit a second audit, I note that the Contractor states that in 2017/2018 two practices were invited to submit replacement audits after the commissioner did not approve their first audits. The Contractor goes on to say that the Contractor was not provided an opportunity to provide an alternative audit which in its view demonstrates inconsistency in the approach taken to other practices.

9.72 I note that, in its representations, NHS England has stated that “there is no obligation on NHS England to allow practices to revise and resubmit evidence that is considered to be non-compliant. However this dispute resolution process has given the practice an opportunity to provide whatever explanations and additional information it wished to NHS England for consideration, both in writing and verbally at the LDR meeting.” In its observations, NHS England further states “In North Curry’s case, the Practice neither contacted NHS England to discuss submitting an alternative audit nor submitted one. Therefore it is not a case of other contractors being treated more favourably than North Curry, but rather that other contractors more actively engaged with the local dispute resolution procedure with a view to resolving matters amicably between the parties.”

9.73 I note that, in its observations, NHS England states that all practices who disputed NHS England’s decision received the same response “To proceed with the dispute resolution process, please submit to us your supporting evidence in relation to this matter.” NHS England goes on to state that “some practices chose, of their own volition, to submit an alternative audit which had been carried out. In some cases, the practice contacted NHS England to ask if they could submit an alternative audit, in which case they were informed that they could submit whatever they wished as evidence for the local dispute resolution process.”

9.74 I am of the view that the onus was upon the Contractor to provide any additional information it wished to be considered at local resolution. I am mindful that the minutes of the meeting held on 24 May 2019 have been included in the documentation I have reviewed and the decision report dated 28 May 2019 has been provided by the Contractor and neither document has been disputed by either party. I am of the view that the Contractor was therefore given the same opportunity as other practices to provide any additional supporting information it so wished to be considered.

9.75 As I have determined that the Contractor’s audit does not relate to dispensing services, and in the absence of any other information provided to me, I conclude that the
Contractor has not participated in a “contractor lead clinical audit of dispensing services” as required by part H.1.3 of Annex H of the SFE. Compliance with the standards and levels of service set out in Annex H is required in order to satisfy the eligibility condition for DSQS payment set out in section 24.3(c). I therefore consider that the Contractor is not eligible for DSQS payment.

9.76 I shall next consider whether NHS England is entitled to recover the DSQS payment made to the Contractor pursuant to the SFE.

9.77 I note Section 25.1 of the SFE states:

“Without prejudice to the specific provisions elsewhere in this SFE, if the Board makes a payment to a contractor under its GMS contract pursuant to this SFE and—

(a) the contractor was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due); …

the Board may recover the money paid by deducting an equivalent amount from any payment payable pursuant to this SFE, and where no such deduction can be made, it is a condition of the payments made pursuant to this SFE that the contractor must pay to the Board that equivalent amount.”

9.78 I consider that Section 25.1 provides a statutory basis for NHS England to recover the monies paid to the Contractor in respect of the DSQS payment. Regulation 23(1) of the Regulations states:

“The contract must contain a term which has the effect of requiring payments under the contract to be made promptly and in accordance with—

(a) the terms of the contract; and

(b) any other conditions relating to payment contained in directions given by the Secretary of State under section 87 of the Act (GMS contracts: payments).”

9.79 I note that the SFE is a set of directions given by the Secretary of State under section 87 of the Act. I therefore consider that the provisions of the SFE form part of the Contract and NHS England has the contractual right to recover the monies.

9.80 I note in its representations to NHS Resolution, the Contractor states that “The additional costs incurred by dispensing practices in order to provide dispensing services are paid for, in part, by participating in the DSQS. Failing an audit results in clawback of funding paid to the Contractor over a year ago in respect of its provision of the Services during the Service Period”.

9.81 I note in its representations, NHS England states:

9.81.1 “Given a contractor’s entitlement to an annual Dispensary Services Quality Payment depends on them satisfying the various requirements set out in the SFE, NHS England is entitled under paragraph 25.1 of the SFE to recover an amount equivalent to the monies paid ‘on account’ given the Practice’s failure to satisfy the Eligibility Conditions.

9.81.2 To minimise the impact on the Practice, NHS England has agreed to recover the overpayment by virtue of deductions across 12 months. However, the Practice was on notice (see NHS England’s Bulletin of 6 April 2018) that payments were being made ‘on account’ and were subject to recovery. Accordingly, it is reasonable to have expected practices to have ring-fenced the monies in the knowledge they were potentially subject to clawback and,
prior to closing their accounts, to have made enquiries of NHS England if they had not heard anything further in relation to their 2017/18 DSQS submission, rather than assuming otherwise. There is no deadline in the SFE by which NHS England must communicate any decision regarding a practice’s compliance with the conditions attached to a Dispensary Services Quality Payment and its entitlement to claw-back monies paid on account.”

9.82 I acknowledge the time NHS England has taken to determine this matter. I am of the view that it is undesirable for NHS England to take this amount of time to notify the Contractor of any issue relating to compliance with the DSQS and impact on the DSQS payment. I note, however, that there are no time limits within the SFE which requires NHS England to communicate its decision in relation to whether a Contractor has or has not met the requirements attached to the DSQS payment. I also note that I have not been advised of any time limits anywhere else in the Contract that may prevent recovery of the DSQS payment.

9.83 I note the following appears on page 6 of the GP Bulletin dated 6 April 2018 / Issue 258 as provided by NHS England in its representations:


We have arranged for payments to be made to all practices who have participated in the 2017/2018 Dispensary Services Quality Scheme (DSQS). As the assessment process is not yet complete this will be an ‘on account’ payment, and subject to recovery later if a practice is assessed as not adequately meeting the requirements of the DSQS.

Please remember that all the requirements of DSQS need to be met for the practice to qualify for payment. Failure to satisfactorily complete any element, including not undertaking enough DRUMs (even by only one or two) or not submitting the DSQS paperwork by the deadline of Friday 20th April, could result in the practice not receiving any payment.”

9.84 I am of the view that the Contractor was aware that it would be paid on account, but that this was subject to recovery if it was deemed not to meet the requirements of the DSQS. As indicated above, I have not been directed to anything in the SFE or the Contract that prevents NHS England from recovery of the DSQS payment at this point in time. I consider that it is the Contractor’s responsibility to ensure it is able to pay back any monies that it has been deemed the Contractor was not entitled to.

9.85 I note NHS England has as stated above agreed to recover the overpayment by virtue of deductions across 12 months. I consider 12 months to be a reasonable amount of time to allow the Contractor to pay back the monies.

9.86 I determine that NHS England is entitled to recover the monies paid to the Contractor in respect of DSQS payment as the Contractor did not meet the eligibility condition for payment of DSQS payment set out in the SFE.

9.87 I note the Contractor in its representations “suggests that to avoid further disputes of this nature there should be further discussion with the stakeholders (BMA, DDA and NHSE) on how the specification should be interpreted and that a list of appropriate audit topics be circulated to all practices at least six months prior to the audit’s due date.” I am of the view that this is a matter for the parties and not something that falls under the remit as set out in the Regulations.

Lisa Hughes
Head of Primary Care Appeals