Contract and IT

January 2016

PSNC Briefing 01/16: Equality Act 2010

This briefing updates "PSNC Briefing 084/13: Equality Act 2010"on the Equality Act 2010 (incorporating its predecessor legislation the Disability Discrimination Act 1995).

Disability Discrimination Act 1995; Equality Act 2010; and Multi-compartment compliance aids

Background

Prior to 2005, some pharmacies dispensed medicines in multi-compartment compliance aids (also known as Monitored Dosage Systems or MDS) either at the pharmacist's own expense or paid for by the patient or the Primary Care Trust (PCT)[1]. Many were supplied free of charge to Care Homes, and some PCTs commissioned a service for supporting people with a disability or who would benefit from the convenience of provision of MDS.

In 2004, the 'New Contract Book' which set out the negotiated position for the pharmacy contractual framework included a proposed Essential Service (Essential Service 7) titled 'Support for People with Disabilities'.

This service was intended to involve a pharmacist carrying out an assessment under the Disability Discrimination Act 1995, and then if appropriate, making an adjustment of either Level 1 (e.g. large print labels, easy open containers, reminder charts etc.) or Level 2 (e.g. dispensing into an MDS). The Department of Health commissioned the development of a resource kit.

Under the Essential Service 7, PCTs would pay the cost of the adjustments, and would be able to carry out their own assessments of patients. For those patients who they deemed ineligible, the pharmacist would be informed not to provide further support as part of the essential services. However, legal advice led the Department of Health to the conclusion that under the Disability Discrimination Act, the PCT would not be able to overturn the decision of the pharmacy contractor, as it is the pharmacy contractor that is responsible for making adjustments under the legislation, and no-one (other than a court) can substitute their views.

[1] As of 1st April 2013, PCTs were abolished:s34 (1) Health and Social Care Act 2012 when commissioning of pharmacy services was transferred to the National Health Service Commissioning Board (also known as NHS England)

This Service was not therefore transposed into the New Contract Regulations as to do so could have led PCTs and pharmacy contractors into legal difficulties.

Because PSNC and the Department of Health had already agreed that funding for supporting patients with disabilities would be made available as part of the new contract funding arrangements, the decision was taken to distribute payment as part of the Practice Payment, as it was assumed that the demand for support under the Disability Discrimination Act would be closely related to dispensing volume.

After the new contractual arrangements came into force in 2005, those PCTs that had been supporting patients by funding the provision of MDS decided to discontinue this, believing that those patients who required MDS to overcome a disability would continue to receive the service under the newly funded arrangements.

Current law

The Equality Act 2010 (**the Equality Act**) provides that a person must not be treated in a discriminatory way because of a "protected characteristic" by service providers (including providers of goods, services and facilities) when that person requires their service. A disability would constitute a "protected characteristic" identified in the Equality Act.

The first matter to consider is whether the patient has a disability. A person is regarded as being disabled, if they have a physical or mental impairment which has a substantial adverse effect on that person's ability to carry out day to day activities. The adverse effect must be "substantial" i.e. not minor or trivial. The Equality Act does not create a spectrum, or sliding scale, running from those matters which are clearly of substantial effect to those matters which are clearly trivial, but rather unless a matter can be classified as 'trivial' or 'minor', it must be treated as substantial.

Additionally, the impairment must be either long term (that is, has lasted more than 12 months) or is likely to last more than 12 months or for the rest of the person's life (for example multiple sclerosis). In deciding whether the impairment is 'likely' to last at least 12 months, or 'likely' to last for the rest of the life of the person affected, the word 'likely' should be interpreted as meaning that it "could well happen" (see HM Government Equality Act 2010 Guidance)

Some persons are deemed automatically "disabled" under the Equality Act. This includes a person certified as blind, severely sight impaired, sight impaired or partially sighted by a consultant ophthalmologist[2]. Cancer, HIV infection and multiple sclerosis are each a disability[3].

If a person is disabled, the provider of services must consider whether a feature of the way in which he provides the service means that the disabled person would not be able to access the service, whereas a non-disabled person would. So for example, a patient with severe arthritis, who is unable to open child resistant

[2] Reg 7 – SI 2010/2128 Equality Act 2010 (Disability) Regulations 2010

[3] Equality Act, Schedule 1, Para 6

containers, would be unable to access their medicines if all medicines supplied by the pharmacy are in child resistant containers.

The provider of the service must then consider whether any adjustment could be made, which would have the result of overcoming the obstacles to accessing the service. In this example, providing an easy open container would overcome the obstacles to accessing medicines. An alternative would be to ensure that there is a care worker available to open the child resistant container every time the patient is due to take a dose.

The provider is likely to be in breach of the Equality Act if a reasonable adjustment is available which he chooses not to make, causing the person to be unable to access the service. In the above example, it would be unreasonable for the pharmacist to provide a care worker to visit the patient to help with opening the containers, but it would be reasonable to expect the pharmacist to dispense medicines in an easy open container.

The Equality Act does not require a provider to carry out an assessment as to whether a person has a "disability" – all that is required, is that the provider makes a "reasonable adjustment", if this is what is needed in order to allow the person to access the service. What is considered a "reasonable adjustment" is subject to the individual situation of the provider and rather unhelpfully the Act does not specify that any particular factors should be taken into account.

However, some of the factors which might be taken into consideration in determining "reasonable" include the extent to which it is practicable for the service provider to take the steps, the financial and other costs of making the adjustment, the extent of the service provider's financial and other resources, the amount of any resources already spent on making adjustments. On this basis, it is more likely to be reasonable for a service provider with substantial financial resources to have to make an adjustment with a significant cost than for a service provider with fewer resources. So what is reasonable for a large national multiple pharmacy may be considerably different to what is considered reasonable for a local small independent pharmacy e.g. providing larger, well-defined signage for people with impaired vision.

The key point here is that the policy of the Act is "*not a minimalist policy of simply ensuring that some access is available to disable people…*"[4] but the "*purpose of the duty to make reasonable adjustments is to provide access to a service as close as it is reasonably possible to get to the standard normally offered to the public at large*"[5] (see Equality Act 2010 Code of Practice Services)

In making a reasonable adjustment a provider is not expected to fundamentally alter the nature of the service.

A provider is considered to have discriminated against a disabled person if they have failed to comply with the duty to make reasonable adjustments. The requirement would protect both existing patients and potential patients of the provider. Providers cannot charge disabled patients for reasonable adjustments.

What are some practical ways of supporting patients?

[4] Para 7.4 of the Code of Practice

[5] Ibid

The majority of patients, including patients in a care home where professional care workers are engaged to assist with medication, do not require any additional support to enable them to access medicines. Patients with a disability may be able to access their medicines without additional support but for some, the pharmacist will need to make reasonable adjustments to overcome obstacles to the use of the service.

Before assuming that the patient requires an adjustment, it is important to establish from the patient, what their personal preferences are; it should not be assumed that a patient who has a disability wants a particular adjustment. Discussing the benefits and shortcomings of particular adjustments with the patient will allow the patient to reach their own decision.

Easy open containers and large print labels are common adjustments. For patients who are forgetful, a reminder chart, showing which medicines are to be taken at particular times during the day may assist – but the pharmacist would need to ensure the patient understands how the reminder chart works, and is able to use it correctly.

For some patients, an MDS may be the only adjustment that will allow the patient to overcome the obstacles to the use of the dispensed medicine.

Whichever adjustment is made to assist patients with a disability, it is essential that the pharmacist satisfies himself that the patient is able to understand and be able to benefit from the adjustment, without introducing additional risks.

It is likely that requests for MDS will be made from a wider group of patients, and their carers (including care workers) / relatives, because of the convenience that MDS brings. There is a long standing position that there is no funding available within the NHS to support the provision of MDS to this group of patients, so the cost may have to be borne by the patient.

What should I take into account when deciding whether to supply MDS?

Before making a supply in MDS, it is essential that the pharmacist satisfies himself that the patient will be able to use the MDS safely. There have been instances involving patients who are confused, who have taken all the morning doses sequentially, by working horizontally across the MDS instead of taking their medicines throughout the day using the vertical compartments. MDS which are produced in a rope like sequence have also been reported to fail, where an individual dose was missed, with the result that every subsequent dose was taken at the wrong time of day. Pharmacists should ensure that whichever type of MDS is used, the patient understands the order in which the medicines should be extracted, and is physically able to do so.

It is known that some medicines start to deteriorate if removed from the manufacturer's original carton, so the impact on these medicines must be assessed before they are repackaged. If PRN (when required) medicines are supplied, these generally are unsuitable for dispensing in MDS. If the supply of an MDS plus additional containers is going to be unmanageable for the patient, then it is possible that the decision to dispense in MDS is flawed, and alternative adjustments may be required.

Given that the purpose behind the Equality Act for a provider to make reasonable adjustments is to avoid the person with a disability from suffering substantial disadvantage in comparison to persons with no disability an adjustment that is likely to cause harm to the patient is not going to be considered a "reasonable adjustment".

In July 2013 the Royal Pharmaceutical Society published "Improving patient outcomes – The better use of multi-compartment compliance aids". This resource is essential reading for pharmacists considering whether to supply monitored dosage systems.

Patients who have care workers

Some patients have care workers engaged to provide support. The care worker may be engaged to assist the patient - in this case the care worker follows the directions of the patient receiving the care. For example the patient would tell the care worker "I want a blue tablet and a green tablet" the care worker would help the patient to select the blue tablet and the green tablet. This may be appropriate if for example, the patient is visually impaired, or if the patient has manual dexterity problems. If a care worker is engaged to assist the patient, the extent of this assistance will be recorded in the care plan.

Alternatively, the care worker may be engaged to administer the medicines – in this case, the care worker makes the decision as to whether the patient needs medicines or not. To do this they must be able to read information whether that is from a reminder chart or the labels affixed to the medicine packaging. Administration does not necessarily mean putting the individual tablets into the patient's mouth. The key criterion is that it is the care worker who makes the decision as to whether there is a particular medicine due at a particular time. The patient may still be able to take the tablets from the packs themselves. If the care worker is engaged to administer the medicines, there will be a record made by the care worker of each administration.

The CQC, the regulator of care worker organisations has two relevant standards[6] linked to medicines.

> ***Outcome 9: Management of medicines***
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> *People using the service:*
>
> - *Will have their medicines at the times they need them, and in a safe way.*
> - *Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf. This is because providers who comply with the regulations will:*
>   - *Handle medicines safely, securely and appropriately.*
>   - *Ensure that medicines are prescribed and given by people safely.*
>   - *Follow published guidance about how to use medicines safely.*
>
> ***Outcome 13: Staffing***
>
> *People using the service:*
>
> - *Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff. This is because providers who comply with the regulations will:*

[6] http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf

- *Make sure that there are sufficient staff with the right knowledge, experience, qualifications and skills to support people.*

The key point from these outcomes is that the organisation providing the care worker must make sure they have sufficient staff with the right knowledge, experience, qualifications and skills to support the people that they are caring for.

If the care plan for the patient requires the care worker to 'assist' the patient as above, then the care worker should have the necessary skills to open containers, and hand the medicines to the patient (whether they are in MDS or original manufacturer's containers). But, the care worker would not be expected to decide whether a particular medicine must be administered at the particular time.

However, if the care worker is expected to administer medicines (as recorded in the care plan), then the care worker should have the qualifications and skills to be able to interpret instructions on the medicines container, whether that is an MDS or a manufacturer's container that has been dispensed bearing the pharmacy dispensing label.

The skills that appear to be needed to administer medicines would include being able to read instructions on labels, and interpret the dosage instructions.

The employer of the care worker should specify the boundaries as to whether the care worker will assist with or administer medicines and it is the obligation of the employer to ensure that the care worker has the requisite skills and qualifications to undertake the roles.

Carer organisations may benefit from seeking the assistance of a pharmacist to provide training to the care workers on interpreting dispensing labels, particularly for those care workers that are engaged to administer medicines. It should not be the case, that carer organisations simply rely on pharmacists to provide medicines in MDS as a matter of routine to lower the skills required of care workers.

If pharmacists believe that a patient has been provided with a carer who is not sufficiently skilled and qualified to provide the required level of support to the patient, then consideration ought to be given to using the raising concerns procedures (as required in the clinical governance section of the terms of service) to alert CQC.

Considerations, when providing medicines in MDS

Whenever a decision is made to provide medicines in an MDS, it must:

- Be appropriate for the patient
- Preserve the integrity of the medicine

As indicated above, some patients who have a disability may need their medicines dispensed in an MDS to allow the patient to access their medicines. But, there should be no general assumptions that patients who have a disability, or who receive multiple medicines would benefit from, or need MDS.

Patients must, if they have mental capacity, be involved in all aspects of their care, and it would be wrong to assume they want their medicines to be repackaged into MDS. A patient in a care home is entitled to manage

their own medicines, if they want to, and pharmacists providing medicines to care homes should be prepared to discuss individual patient's requirements, where the patient has exercised the right to deal with their own medicines arrangements.

In some cases, the families or care workers of patients who suffer from a degree of confusion may suggest that the patient will benefit from having their medicines provided in an MDS. Sometimes, the provision of medicines in an MDS may be a substitute for other more appropriate arrangements, and there is a danger of patients being left alone, with an MDS, by family and care workers who believe that the patient will be able to manage their medicines when presented in that way. These assumptions could be dangerous for the patient – and as the decision to remove medicines from a manufacturer's pack and place them in an MDS is that of the pharmacist; it is the pharmacist who should satisfy himself that the patient can understand and be able to use the MDS trays. Therefore before providing medicines in an MDS, pharmacists should ensure that this will not lead to a false sense of security for others involved with the care of the patient i.e. the assumption that just because medicines have been dispensed into an MDS, it follows that the patient can understand how to use the MDS.

If an assessment under the Equality Act determines that the patient would not be able to handle their medicines if they were not in an MDS, then this poses problems if there are any medicines that cannot be placed in the MDS for example, hygroscopic medicines, PRN medication and liquids. If they are not in the MDS, then the use of the MDS for example to overcome confusion may not be effective, as the patient will need to identify the medicines to take, from two containers, the MDS and the other medicine containers – in other words, it would be no different to the dispensing in two manufacturer's containers – an outcome that the MDS is trying to avoid. There is a risk that the patient might not remember to take the products dispensed separately to the MDS.

All medicines that have been manufactured and supplied in manufacturer's cartons have been tested for stability in those cartons. Removing medicines from the manufacturer's carton poses a risk to the quality of the medicine.

As stated above, the Royal Pharmaceutical Society has published guidance on improving patient outcomes, and pharmacists will need to consider this when making the professional decision whether or not to supply an MDS.

Is there a link to prescriptions and period of treatment?

There is no fundamental link between dispensing in an MDS and the period of treatment covered by a prescription. A prescription for 28 days' supply might be dispensed in an MDS, and a prescription for seven days might be supplied in the original manufacturer's carton.

Once medicines have been dispensed by a pharmacist, whether in an MDS or in manufacturer's cartons, then no further changes to what has been dispensed should be made by a pharmacist. If a prescribed medicine is no longer required, the prescriber should inform the patient of that clinical decision, and ensure that the patient understands that previously dispensed medicine should not be administered. If the medicine has been provided alongside other medicines in an MDS, it might be acceptable for the prescriber to advise the patient not to take the particular product if it is readily identifiable visually by the patient. But if the MDS was provided

because of a disability and the patient does not have the ability to identify and discard the medicine, when opening each compartment, then the whole MDS would need to be replaced. This is potentially very wasteful, because all the medicines contained in the MDS will need to be re-prescribed. The NHS terms of service for pharmacies does not require pharmacists to modify previously provided MDS trays.

For patients requiring medicines in MDS as a reasonable adjustment under the Equality Act, the prescriber may decide to prescribe in 7 day quantities, to minimise the amounts of waste that would occur on medication changes. This would be a clinical decision of the prescriber, just as the decision to dispense in MDS is a decision solely for the pharmacist.

Funding Issues

When an NHS prescription is presented in a pharmacy, any medicines prescribed must be dispensed 'with reasonable promptness'. If the patient requires an MDS because of a disability, then the pharmacist must make that adjustment. It is not permitted under the terms of service, for a pharmacist to turn away a prescription, simply because the pharmacist does not want to dispense the medicines in MDS because of the cost of the equipment and the time commitment. Occasionally, pharmacists contact PSNC to express concern about the number of patients who attend their pharmacy, having tried to have it dispensed elsewhere, only to be refused. This should be notified to the local NHS England team.

Some of the queries that PSNC receives about support for patients who have a disability concern instructions given by prescribers on the prescription, to dispense weekly into compliance aids. The NHS pharmacy terms of service do not impose a requirement to dispense into compliance aids or to dispense in instalments (other than instalment prescriptions for the treatment of substance misusers). Therefore a prescription ordering 28 days treatment should be dispensed on one occasion as the NHS requires the medicine to be dispensed on the one occasion, for one dispensing fee. It is for the pharmacy contractor to decide whether it is appropriate to dispense into MDS and this decision is not influenced by the period of treatment.

If a prescription for 28 days treatment is issued for a patient who satisfies the Equality Act 2010 criteria, and the pharmacy contractor decides that the adjustment required is an MDS, then 4 x 7 day MDS containers or 1 x 28 day MDS container should be prepared and supplied to the patient on a single occasion.

As stated above, there is no obligation on pharmacy contractors to amend what has already been dispensed, so if changes are made to a patient's medicines part way through the period of treatment, the prescriber would be obliged to make their own Equality Act adjustment, by issuing a prescription for all the current medicines, so that they can all be dispensed into a new MDS. For this reason, prescribers could be advised to issue 7 day prescriptions, if the patient is likely to have changes made to prescribed medicines.

Convenience / Concordance MDS

There are some patients whose GPs (or care workers) believe would benefit from MDS, but who are not disabled, or whose disability does not justify the use of MDS. In these cases, MDS may be provided at the patient's expense, or the pharmacist might be willing (for pragmatic or other purposes) to provide MDS free of charge. But, the cost of the equipment and the resources necessary to dispense into MDS are much higher than dispensing the manufacturer's original carton, particularly if the activity is being carried out on a monthly

basis (since four separate weekly MDS containers must be dispensed). In these circumstances, the pharmacist may be willing to provide an MDS only if the GP is supportive of the use of the MDS. Consider the position above, where a medicine is changed mid-way through a period of treatment – in the event of a change of medicines for a patient receiving the medicines in MDS due to Equality Act obligations, the GP would need to make an adjustment by issuing a replacement prescription. If the patient was supplied the MDS for a reason other than disability, the GP's willingness to issue another prescription, to replace wasted medicines may not be so forthcoming. Therefore, GPs have demonstrated their support for MDS by prescribing in weekly quantities, to make the workload manageable for the pharmacist, and to minimise the waste should the patient's treatment be changed.

If the GP is not supportive of MDS (and would not welcome the extra demands on his time or prescribing budgets, if replacement prescriptions had to be issued), then he ought to make this known to the patient and pharmacist so that the patient is not suddenly left with a part used MDS and no replacement prescription.

Questions

Q. **Must I always carry out an assessment under the Equality Act 2010, if a patient asks me to make an adjustment to the way in which I normally dispense, because of a disability?**

A No. The legislation does not require a formal assessment to be carried out, only that a reasonable adjustment is made to help a disabled person overcome the obstacles to the use of the service. A pharmacy could provide compliance aids (such as easy open containers, reminder charts/alarms, dexterity aids, winged or plain bottle caps) if they decide with the patient, that this will assist the patient to use the service.

HOWEVER – if an adjustment is made, the pharmacist is responsible for the decision. If the adjustment causes harm, the pharmacist could be liable – for example, providing a reminder chart that the patient is not able to understand, or an MDS which results in incompatibilities or deterioration of the medicines.

Q. Where can I find an assessment toolkit?

A. The Department of Health commissioned a resource kit, which appears on the PCC website but is not "officially" a DH or PCC document. The use of this resource kit is not mandatory but might be useful to inform process stages of requests from patients/carers for auxiliary aids.

Q. **A patient in a care home has requested that we dispense medicines in easy open rather than child resistant containers. If the home has staff able to assist, is this necessary?**

A. If the patient wishes to manage their own medicines, and the arrangements have been made for the patient to retain their own medicines, then this may be an appropriate reasonable adjustment, because it allows the patient to maintain their independence.

Q. **A patient has severe visual impairment, and has successfully used an MDS tray to be able to take their three medicines which are all similar sizes and shapes, so cannot be identified by touch. The latest prescription includes two additional drugs - one is hygroscopic and must be dispensed in its original container, and the other is a PRN analgesic, so neither can be put into the MDS tray. Is it still appropriate to use MDS, if the patient's medicines are supplied in this plus two other containers?**

A. Where the reason for dispensing in MDS is not because of confusion, and alternative methods can be used to allow the patient to identify their medicines correctly, then the MDS remains appropriate. But, if the purpose of the MDS is because they need the 'reminder' of which medicines to take at particular times of day, then supplying other medicines (in this case, the hygroscopic medicine) may be inappropriate, since that may be missed by the patient. The dispensing of a separate container for PRN medicines may be appropriate alongside the MDS, if the level of confusion is not great, and the patient understands that 'when required' medication is in another container. If the medicines (one hygroscopic to be taken regularly and one to be taken PRN) are excluded from the MDS and the patient has confusion such that MDS is the adjustment necessary to overcome the obstacles to taking the medicines, then there may be confusion over which is the regular medicine and which is the analgesic. The pharmacist should discuss with the patient, what their needs are, and determine whether the patient's treatment or safety will be compromised.

Q. **A housebound patient's care worker has asked me to dispense the patient's medicines in a compliance aid i.e. MDS, because the care worker finds this easier and quicker to use than individual manufacturer's containers. Do I need to comply with that request?**

A. It is the patient's needs that must be addressed. The pharmacist will need to be satisfied that the request for a compliance aid would constitute a "reasonable adjustment" in terms of actually helping a disabled person to overcome the obstacles to the use of the pharmacy. If so, patient's medicines are likely to be appropriately dispensed in an MDS.

However, it is not for the care worker to determine the appropriateness of whether to dispense patient medicines in a compliance aid. Care workers tend to be employed to provide care to people (for example in their own homes or in care homes) and are not directly regulated. Though as indicated above organisations employing the care worker are subject to CQC's regulations and the outcomes which CQC expect people using a service will experience if the organisation is to be compliant with CQC regulations.

In March 2015, the Care Certificate was introduced and is an identified set of standards that health and social care workers must adhere to in their daily working life. The aim of the Care Certificate is to provide everyone the confidence that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Any person (individual, partnership or organisation) who provides a "regulated activity" in England must be registered with CQC. As part of registration, CQC expects that those who employ care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as a benchmark for staff induction.

One of the key standards which care workers must adhere to is to understand medication and healthcare tasks (see Care Certificate Standards). Therefore, if the care worker is engaged to administer medicines, then they must have sufficient knowledge, experience, qualifications and skills to be able to undertake that activity. The convenience of the care worker could be a valid practical consideration, but this would not be funded under existing NHS arrangements. If care workers make repeated requests for MDS, try to ascertain why, and if appropriate, consider contacting the care worker's employer or CQC if you believe that the level of experience, knowledge, qualifications and skills appear inadequate.

Ultimately, it is the pharmacist's decision as to what is the appropriate "reasonable" adjustment/s for the individual patient, not a care worker or other healthcare professional.

Q. **I have decided to dispense a patient's medicines in an MDS because the patient has a disability, and between us we have determined that the MDS provides the best way of allow the patient to access their medicines. Unfortunately, due to intolerance of one of the medicines, the GP has prescribed an alternative and has asked that I replace this in the previously dispensed medicines. Can I do this?**

A. Once a medicine has been dispensed, the NHS pharmacy terms of service do not require any further adjustments. Therefore, unless the GP has instructed the patient to ignore any of the discontinued medicines from the MDS, and is confident that the patient will do this and be able to take the separately dispensed replacements, the whole MDS container should be discarded, and a new one produced. As the decision to dispense in an MDS was on disability grounds, it is possible that the patient will not be able to handle a separately dispensed item, and if this is the case, there is no alternative but for the GP to issue a new prescription for all current medicines, so that they can be dispensed together in a replacement MDS.

This is wasteful of the medicines already dispensed, and is the reason why GPs may prefer to prescribe on a weekly basis if the patient is likely to have changes made to the medication.

Indeed, pharmacists can charge patients for repackaging (if they are not entitled under the Equality Act) but many pharmacists and GPs have come to a pragmatic solution using seven day prescriptions. This does not provide any additional funding to the pharmacy – he/she still carries out one dispensing activity per prescription, but now does so four times more often than once a month. Pharmacies with under-utilised staff may have the capacity to handle seven day prescriptions, but a pharmacy at or near capacity may not be able to safely dispense these additional prescriptions (i.e. these more frequent prescriptions) without engaging more staff.

Q. **In the Drug Tariff, the practice payment is stated to include 6.6 pence 'contribution in Practice Payment for EA'. What is this payment for?**

A. In 2005, the funding agreed for the pharmacy contractual framework included a sum towards the pharmacist's compliance with the then Disability Discrimination Act (now the Equality Act). This sum is not distributed specifically for any adjustments made, but is distributed on a flat rate basis, towards any adjustments that the pharmacy makes. It is therefore towards the funding for easy open containers, large print labels, reminder charts, MDS etc.

Q. **In that case, would it be right to say that I am funded for providing MDS on request?**

A. No. The funding is towards compliance with the Equality Act. If a patient requires an MDS because they have a disability, and the MDS is the only reasonable adjustment for overcoming the obstacles to using the dispensed medicines, then that will be funded by the Equality Act element of the practice payment. It will not cover MDS provided as a convenience, or where the MDS is being used for a purpose other than Equality Act support.

Q. **Can the GP insist that I dispense a medicine in an MDS?**

A. No. It is the responsibility of the pharmacist to comply with their obligations under the Equality Act and, ultimately, the courts will definitively determine whether the pharmacist has complied with their duty to

make “reasonable adjustments”, if challenged. The final decision whether or not to use MDS for a patient with a disability rests with the pharmacist.

Nevertheless, if a GP is supportive of MDS to provide greater convenience for the patient, or to improve concordance, then the GP could ask if the pharmacist is willing to dispense in an MDS. Because of the additional costs of equipment and time dispensing in an MDS, particularly on a monthly basis, and the risks of wastage (if medicines are changed), the agreement of the pharmacist may be dependent on the GP prescribing on a weekly basis.

Q. **The GP has agreed to provide prescriptions on a weekly basis so that I can supply MDS. He has provided four weekly prescriptions at once – can I dispense all four weekly MDS together?**

A. No. The purpose of weekly prescriptions is to support the supply of MDS containers on a weekly basis, and to minimise waste i.e. if there were to be a change to the patient’s treatment. Dispensing all four MDS containers at once would defeat the purpose, and likely create unnecessary waste.

Further support on the Equality Act

If you have queries on this PSNC Briefing or you require more information please contact Steve Lutener, Director of Regulation and Support.