20th June 2022

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Sent via email: pharmacy@health-ni.gov.uk
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Dear Cathy,

2022 DoH(NI) Consultation on Community Pharmacy Drug Reimbursement Reforms

Introduction

Community Pharmacy Northern Ireland (CPNI) is the representative body for the 526 community pharmacies in Northern Ireland. As such, CPNI represents community pharmacy contractors in negotiations with the Department of Health (NI) and the Strategic Planning and Performance Group (SPPG), previously HSCB, in the development and delivery of community pharmacy services and the community pharmacy contractual, remuneration and reimbursement arrangements.

CPNI welcomes the opportunity to respond to this targeted Consultation on Community Pharmacy Drug Reimbursement Reforms (2022). We also acknowledge the DoH(NI)/SPPG briefing session with CPNI on 28th April 2022, the extension of the initial 8-week consultation period to 20th June 2022 and the co-operation of SPPG and DoH(NI) in seeking to obtain further information for CPNI from DHSC (London) who had undertaken a similar consultation in 2019 and who, we understand, plan to implement reimbursement changes to the English Drug Tariff later in 2022/23.

It is important that I state at the outset the significant and positive progress that has been made here since early 2020 in relation to community pharmacy service development, the agreed commissioning plans, and associated remuneration arrangements. This has been achieved through the collaborative working of DoH(NI), SPPG/HSCB and CPNI representatives, Ministerial support and the important contribution by community pharmacy teams across Northern Ireland in supporting patients and the health service.

The financial envelope is comprised of remuneration and reimbursement elements. This consultation provides CPNI with an opportunity to not only consider the specific reimbursement proposals contained in it but also to put forward views on wider reimbursement aspects that are relevant to the Northern Ireland Drug Tariff (NIDT) and the safe provision of community pharmacy services in Northern Ireland.

General Comment

DHSC is the main UK authority that has responsibility for determining and setting reimbursement prices for the English Drug Tariff. The English prices are then used to inform the drug tariff reimbursement arrangements in each of the 4 UK countries. DoH(NI) by virtue of not being in a position to determine drug reimbursement prices has depended on DHSC to undertake this function and, as has been the case since April 2011, DoH(NI) applies the English Drug Tariff Reimbursement arrangements directly to NIDT.

Apart from Proprietary Mitigation payments (2012/13-2017/18) and NCSO (c2012-2014) no adjustments have been made to the source English Drug Tariff reimbursement arrangements within NIDT to reflect Northern Ireland factors.

CPNI assumes that the intention of DoH(NI) is to apply the new English Drug Tariff reimbursement arrangements to the NIDT given that DoH(NI) has replicated all Drug Tariff changes when introduced by England since 2011. It is important to state that the English Drug Tariff is based on agreement between DHSC/NHSE&I and PSNC, which represents pharmacy contractors in England, on the totality of the English Community Pharmacy remuneration and reimbursement arrangements and does not reflect Northern Ireland's community pharmacy contractual arrangements. Simply applying new English Drug Tariff reimbursement arrangements into NIDT without adjustment will only compound demonstrable reimbursement differences that have impacted contractors here since April 2011. We would ask that DoH(NI) and SPPG fully consider the points outlined in our Consultation response and to work with CPNI to introduce mitigations and Drug Tariff adjustments, reflective of Northern Ireland's circumstances that are very different to those in England, so that we can collectively stabilise and enable the community pharmacy sector to deliver on the objectives of the 2022/23 – 2024/25 Community Pharmacy Commissioning Plan. Irrespective of whether England proceeds to change their Drug Tariff Reimbursement arrangements in 2022/23 work is required to urgently address deficiencies with current NIDT reimbursement arrangements.

DoH(NI) Drug Reimbursement Reforms Consultation.

DoH(NI) helpfully lays out some of the Statutory considerations relevant to community pharmacy remuneration and reimbursement arrangements within the consultation document. The full range of obligations on DoH(NI) to maintain Drug tariff arrangements for Northern Ireland that i) meet statutory remuneration and reimbursement obligations and ii) are fit for purpose are well established. I do not propose to re-state them here.

The purpose of the DoH(NI) Drug Reimbursement Reforms Consultation is to seek CPNI views on

> *a number of community pharmacy drug reimbursement reform proposals that DHSC are now planning to implement following a similar consultation undertaken in England in 2019. As the NIDT is currently reflective of the English Drug Tariff, any changes made to the English Tariff may be reflected in the Northern Ireland Drug Tariff. The Department of Health plans to use this consultation to seek views on the proposed DHSC changes to the community pharmacy drug reimbursement and potential impacts.*
>
> *Subject to the outcome of this consultation, the Department of Health would wish to maintain alignment of the Northern Ireland Drug Tariff with the England Drug Tariff.*

DoH(NI) are specifically seeking CPNI's views in this Consultation on the following DHSC proposals:

1. Using actual purchase, sales and volume information to set **Category A reimbursement prices** which would include medicine margin (but this margin would not be adjusted to achieve the annual amount of medicine margin) rather than the current weighted average methodology based on prices provided by 4 Manufacturers' and wholesalers' price lists,

2. Using either i) the weighted average of the relevant suppliers' list prices as per dm+d, or ii) actual sales and volume data from suppliers to determine the reimbursement prices of generically prescribed **Category C** reimbursement prices**,** instead of the current methodology using supplier's list price,
3. Adding less medicine margin to those **Category M** generic medicines (for which branded equivalents are available and that are priced below the generic medicine) and consequently adding more medicine margin on all other Category M medicines,
4. Splitting the **Discount Recovery Scale** into two separate scales, one for generic medicines and one for branded medicines.

CPNI sets out its responses to the actual Consultation questions in Appendix 1, but we would ask that the points in this cover letter are considered an intrinsic part of the CPNI response to the consultation.

No Economic Impact assessment has been included with this Consultation making it practically impossible for CPNI to assess, model or understand the impact of the proposed changes on the Northern Ireland community pharmacy reimbursement arrangements. This is a major concern. Inclusion of an Impact Assessment is considered an important element of any proper statutory consultation process.

We are not aware of an Impact Assessment having been carried out by DHSC when DHSC consulted on these proposals in England in 2019 but in any event modulation of the English Drug tariff will be possible by monitoring the economic changes in England after the reimbursement changes are applied and re-calibrating English Drug tariff reimbursements to ensure compliance with the agreed 5-year English CPCF agreement, specifically in relation to the £800m Retained Purchase Profits that has been agreed with PSNC. For the reasons outlined below CPNI views neither the English community pharmacy market nor the English contractual arrangements as comparable to Northern Ireland nor do we believe the subsequent adjustments that might be made to the English Drug Tariff will be appropriate for Northern Ireland. Accordingly, CPNI contends that the direct application of the proposed English Drug Reimbursement proposals, without adjustment for NI factors, is inherently flawed and will lead to further reimbursement difficulties for Contractors here.

CPNI has 2 fundamental concerns with the proposals in this consultation and we would ask DoH(NI) and SPPG to consider the following:

1. No adjustments or weightings have been proposed by DoH(NI) to take account of either the differences that exist in either the make-up the Northern Ireland community pharmacy sector or the wholesale supply chain (that supply Community Pharmacies in Northern Ireland), relative to England.

2. Current NIDT reimbursement deficiencies need to be addressed before further NIDT changes are considered/introduced to avoid compounding extant reimbursement difficulties that stem from an incorrect level of Retained Purchase Profits (RPP) being applied to the Northern Ireland Community Pharmacy financial envelope.

Further information on these aspects is outlined below.

1. Absence of any adjustments or weightings being proposed to reflect NI factors.

Proposals by DHSC to change English Drug Reimbursement arrangements associated with Categories A, C and M medicines will negatively impact on achievable retained purchase profits in Northern Ireland if directly applied, without adjustment, for the following reasons:

- Differences in the number of wholesalers and suppliers of medicines to Northern Ireland as well as medicine supply constraints because of EU Exit will result in higher acquisition prices for medicines in Northern Ireland relative to GB. NI only has a 3-4% share of the UK medicines economy so the influence of Northern Ireland's higher acquisition prices being materially reflected in setting the

source English DT reimbursement prices is negligible. The consequence of this is that the subsequent English Drug Tariff reimbursement prices would be lower than what would be the case if Northern Ireland set its own prices.

- The greater proportion of medium and large multiple pharmacy groups relative to independents in England compared to Northern Ireland also negatively distorts the reimbursement prices set by England to a greater extent than would be the case if Northern Ireland set its own reimbursement prices.

- We anticipate that Northern Ireland has a different split in terms of Cat-A, -C, -M and brand medicine spends compared to England/GB. This can also be anticipated going forward. The difference is a result of different Northern Ireland prescribing policies e.g. Cost Effective Choices and PCEP policies etc. In England, we assume the category spend ratios are considered and modelled accordingly when setting English reimbursement prices to achieve the target £800m RPP. Due to Northern Ireland having different category spend ratios it is not correct therefore to assume a pro-rata opportunity for RPP exists in Northern Ireland. The proposed 2022 Drug Reimbursement Reforms will distort that assumption further.

- EU Exit and Northern Ireland Protocol legislation, specifically in relation to PL(GB) licensing, will result in Northern Ireland pharmacies having reduced access to parallel import medicinal products and therefore products in this category will be subject to an overall higher relative cost.

The combined effect of these is that Northern Ireland pharmacies will experience a combination of higher acquisition costs and lower reimbursement prices than would be the case if DoH(NI) determined reimbursement prices using NI-only purchase data. This clearly disadvantages Northern Ireland contractors because the actual RPP achieved will be lower than the theoretical RPP that is assumed by the application of a 1/30th pro-rata approach to English Drug tariff and RPP arrangements.

2. Requirement to address current issues with Northern Ireland Drug Tariff arrangements before implementing these proposed Drug Tariff changes.

Current NIDT reimbursement arrangements linked to the current £26.5m RPP have not been the subject of negotiation and agreement between our respective organisations since March 2011. The application of the English Drug Tariff reimbursement arrangements, including a somewhat arbitrary 1/30th fraction to the agreed English level of RPP, caused significant difficulties for contractors and strained the relationship between our respective organisations in 2011/12 and subsequently. The absence of carrying out a meaningful impact assessment prior to April 2011 meant that the financial impact on contractors could only be assessed from 2011/12 i.e., after the event. Several high-level comparisons outlined below illustrate the extent to which Community Pharmacy owners in Northern Ireland have been disadvantaged compared to pharmacy owners in England and Scotland following the introduction of the English Drug Tariff reimbursement arrangements to NIDT without adjustment.

- **An additional £10.6m clawback was deducted from Contractors in 2011/12 after DoH(NI) switched from using the Scottish dual clawback rates to the English Discount Recovery Scale in April 2011 (Ref PST/1 Reports March 2011 and March 2012).**

  In 2010/11 the amount of Clawback deducted from Northern Ireland Contractors was £23.3m. After adopting the English discount recovery scale, the amount of Clawback deducted in 2011/12 increased to £33.9m. Clawback in the range £27.9m - £33.9m has been deducted in each of the years from 2011/12. In cumulative terms, NI Contractors have been disadvantaged by **over c£70m** in additional

clawback being reclaimed in the period 2011/12 to 2020/21 simply because of the switch from the Scottish dual clawback rates to the English DT Discount Recovery Scale in April 2011.

- **The use of £26.5m RPP in Northern Ireland gives rise to significant disparities when various NI Community Pharmacy funding datasets are compared to similar datasets for England and Scotland.**

    - £26.5m as a percentage of the Northern Ireland Gross Ingredient Cost (GIC) Drug Spend in 20/21of £453.8m is **5.8% (Ref PPA Report Apr2020 – March 2021).**

        - In England, £800m RPP as a percentage of the 20/21 England GIC of £8971.5m is **8.9% (Ref** PD1 reports | NHSBSA).
        - In Scotland the guaranteed £80m RPP as a percentage of the 20/21 Scottish GIC. £1118.23m is **7.1%**, this can increase to at least **8.0%** under profit sharing arrangements in their contractual arrangements (Ref PHS Dispenser payments and prescription cost analysis - financial year 2020 to 2021).

    - £26.5m, as a percentage of the overall 21/22 allocated Northern Ireland community pharmacy funding c(£140m, excluding c£5m SRP) is **18.9%**

        - In England £800m RPP approximates to **30.8%** of the £2.592bn CPCF funding allocated for 2022/23.
        - In Scotland £80m RPP approximates to **27.7%** of the guaranteed funding of £287.98m allocated for 2022/23 (Ref PCA (P)(2022) 8). £90m RPP would increase that to 31.2%.

    - Category-M reductions in 21/22 have had a disproportionate negative effect on the NI reimbursement when compared to England. From our assessment, changes to the English Cat-M prices designed to cumulatively reduce reimbursement in England by £16.3m/month from July'21, £8.9m/month from 1st October and £16.4m/month from January'22 (Ref Drug Tariff Part VIII | NHSBSA) impacted Northern Ireland Contractors by c£0.79m/month, c£0.45m/month and c£0.83m/month. These Northern Ireland reductions approximate to a 1/20th impact rather than 1/30th.

- **Use of Adjustments by Scottish Government in the Scottish Drug Tariff.**
  While Scotland uses the English reference drug prices to inform the Scottish Drug Tariff reimbursement arrangements Scotland adjusts its tariff in 2 ways to ensure that the drug tariff provides remuneration and reimbursement in accordance with the contractual agreement between Scottish Government and CPS.
    - The Scottish Drug Tariff uses dual discount recovery clawback rates. Published information confirms that a Zero rate of clawback has been applied for generics in 21/22 and 22/23 and that the clawback rate for qualifying brand medicines has been in the range 3.87% - 5.03% since May'20 (here) (Ref PCA(P)(2020)1, PCA(P)(2020)10, PCA(P)(2020)15, PCA(P)(2021)5, PCA(P)(2021)21 and PCA(P)(2022)8.
      In 2020/21 **£17.13m clawback** was deducted from a total **GIC of £1,118.2m** in Scotland (Ref PHS Dispenser payments and prescription cost analysis - financial year 2020 to 2021). This compares to £29.8m clawback deducted in Northern Ireland from a total GIC of £453.7m in 20/21 and £28.2m clawback deducted from a total GIC of £455.6m in 21/22 (Ref PPA reports Apr2020 – Mar2021 and Apr2021 – March 2022).

    - The Scottish Drug Tariff also applies adjustments to set their Part 7 generic reimbursement prices. Our assessment of the Scottish reimbursement prices relative to the English Part 8

prices in the first quarter 2022 show that of the c635 lines common to both tariffs, Scotland had higher Drug Tariff prices in over 400 of these lines relative to England (and Northern Ireland) before factoring in Concessionary Prices.

The Scottish Drug Tariff therefore actively adjusts the source reimbursement information obtained from England in a contemporaneous manner to ensure funding is tailored and delivered in accordance with the agreed contractual arrangements in Scotland and not by applying a pro-rata basis to the England drug tariff arrangements.

Tribal Consultants Advice to DoH(NI) in 2010 on Adjustments to NIDT

Prior to the introduction of the English Drug Tariff reimbursement arrangements to the NIDT in 2011/12 Tribal Consultants advised DoH(NI) that:

> ***Whilst the recommended option involves taking pricing information from Part VIII of the English Drug Tariff it is not intended that this information should be incorporated into the Northern Ireland Drug Tariff without considering what adjustments might be required to ensure that the Northern Ireland Drug Tariff remains fit for purpose. As such the intention is not that Northern Ireland follows Part VIII of the English Tariff but uses it as a reference point from which reimbursement, remuneration and discount rates can be adjusted as required.***

This recommendation was significant and important, but it was disregarded by DoH(NI). The difficulties that this led to should not be repeated. It is important that the opportunity is taken to incorporate this Tribal recommendation in the NIDT workplan as a priority. CPNI would contend that evidence exists on the range of factors that differentiate Northern Ireland from other parts of the UK. These include the distribution and categories of pharmacies in Northern Ireland, the range and level of Community Pharmacy service provision in Northern Ireland, the higher health needs of the Northern Ireland population, the greater socio-economic needs of the population, rurality factors and legacy issues associated with the Troubles to name but a few.

For the reasons stated CPNI considers NIDT reimbursement arrangements have demonstrably disadvantaged Community Pharmacy owners in Northern Ireland since 2011/12 compared to Drug Tariff arrangements in other parts of the UK. Fundamentally the RPP level of £26.5m is wrong. From this stems a NIDT that inherently gives rise to Northern Ireland Community Pharmacy owners being disadvantaged in the past and who will be further disadvantaged in the future if the DHSC proposed Drug Reimbursement Reforms are applied to NIDT without adjustment. Instead, we should accelerate work to agree an appropriate retained margin level for Northern Ireland, using appropriate and agreed clawback rates for brand and generic medicines and specific product price adjustments as needed to deliver an agreed RPP, mitigating accordingly in the interim until the new arrangements are implemented.

Conclusion

CPNI welcomes the opportunity to respond to the DoH(NI) Drug Reimbursement Reforms Consultation. This consultation provides an opportunity to build on the collaborative and progressive remuneration negotiations that have taken place with HSCNI officials over the last 2 years and to start the process of addressing long-standing DT reimbursement issues. This has to include applying a range of adjustments to NIDT, agreed by DoH(NI), SPPG and CPNI, so that the totality of the remuneration and reimbursement arrangements ensure the statutory obligations to provide fair and reasonable funding, reflective of costs, is provided to community pharmacy owners.

CPNI, in responding to this consultation, has taken an assertive, but constructive and balanced approach in setting out its' concerns. We would wish to take forward, in a collective and collaborative manner, the work that will be needed to progress these NIDT discussions in the same manner that has characterised our working on remuneration aspects since 2020.

CPNI recognises the obligation on DoH(NI) and SPPG to obtain value for money for health service funding but we believe fundamental community pharmacy reimbursement issues still need to be resolved. This will require investment in the sector through NIDT. If England moves quicker and introduces the proposed changes to the English Drug tariff before we can fully agree and implement the necessary adjustments to the NIDT then mitigations will be required for the Northern Ireland community pharmacy sector so that stability of the network can be maintained. This is important as we take forward the 3-year Commissioning Plan in a period that is characterised by unprecedented rises in the cost of providing community pharmacy services. CPNI would be keen to explore the opportunity to deliver a reimbursement model closer to that which exists in Scotland; we believe this would be timely and a means of underpinning the agreed Commissioning Plan and community pharmacy service provision going forward.

We look forward to early and progressive engagement on these matters.

Yours sincerely

Gerard F. Greene.

_____

GERARD F GREENE *MPSNI*
Chief Executive

cc Bernie Duffy Bernie.Duffy@health-ni.gov.uk
Kathryn Turner kathryn.turner@hscni.net

ANNEX A

Consultation Response Form

CONSULTEE DETAILS

Name (Optional): **Gerard Greene**

Organisation and job title (if applicable): **Chief Executive**

Please provide details of your postal and/or email address if you wish to be advised of any outcome of the consultation.

Postal address (Optional)

Email address (Optional) **ggreene@communitypharmacyni.co.uk** PA: kdouglas@communitypharmacyni.co.uk

I am responding: as an individual on behalf of an organisation (Please tick a box)

If replying as an individual, please indicate if you do not wish for your identity to be made public

Yes ✓ No ☐

Whilst not essential, it would assist the Department in analysing responses if responding on behalf of an organisation you could provide details of who your organisation represents and, where applicable, how the views of members were assembled.

PART A

Views are invited on the following questions.

Proposal 1 - Changes to the determination of reimbursement prices of generic medicines in Category A

Q1 Do you agree with this proposed reform?

~~Yes~~ **No** ~~Don't know/no views~~

Q2 Do you have any comments on this proposed reform?

CPNI welcomes the opportunity to make amendments to the Northern Ireland Drug Tariff to arrive at a Drug Tariff that is fit for purpose, reactive to the market and delivers fair and reasonable remuneration for contractors. CPNI is keen to discuss options with DoH and SPPG colleagues, but at this point believes this proposal does not provide enough information in order to reach a definitive conclusion. CPNI does not have visibility regarding the information on pricing that is supplied on a quarterly basis under the Health Service Products (Provision and Disclosure of Information) Regulations 2018. CPNI does not understand how relevant this information is to the Northern Ireland market, nor how the information that is available would be applied to the Northern Ireland Drug Tariff prices. CPNI could not support the use of prices from suppliers who do not supply to Northern Ireland or prices that do not reflect the Northern Ireland market. This proposal is also based on quarterly information which CPNI believes would be a retrograde step from the current system which reacts to price changes monthly.

CPNI does not have detail on how the medicines margin on category A medicines would be set. CPNI would have concerns around applying a fixed margin and the impact this may have on both competition within the market and on contractors' ability to achieve margin that is critical to the

overall funding of the community pharmacy network via RPP. These proposals in England are on the basis of an agreed community pharmacy contractual framework underpinned by an agreed financial envelope in England, however Northern Ireland does not have an agreed financial envelope and CPNI has always maintained that the level of RPP in Northern Ireland is incorrect.

In the absence of these funding agreements, it is difficult to agree to these proposals prior to a financial settlement being reached that would give a degree of reassurance and protection to contractors that any changes would be within agreed parameters.

Proposal 2 - Changes to the determination of reimbursement prices of medicines in Category C which are prescribed generically but have multiple suppliers

Q3 Do you agree with this proposed reform?

~~Yes~~ **No** ~~Don't know/no views~~

Q4 Do you have a preference for option 1 or option 2?

~~Option 1~~ ~~Option 2~~ **- no preference**

Q5 Do you have any comments on this proposed reform?

CPNI would have concerns with both options that have been outlined under this proposal including how reactive the pricing mechanism will be to price changes, the risk to contractors of dispensing at a loss and access to medicines for contractors and ultimately patients. This proposal would need to take into account the availability of these products to a Northern Ireland market and the prices that would be applied. While a range of suppliers may offer the product, they may have limited amounts of stock available to Northern Ireland and this would need to be factored in when prices are being set. CPNI would also suggest that Northern Ireland has a different dispensing mix compared to England, particularly in relation to branded generics, and this would need to be considered before any changes were implemented.

Proposal 3 - Changes to the determination of medicine margin added to generic medicines in Category M

Q6 Do you agree with this proposed reform?

~~Yes~~ **No** ~~Don't know/no views~~

Q7 Do you have any comments on this proposed reform?

CPNI would have concerns with altering the margin available on specific category M medicines and the unintended, and potentially inequitable, consequences this may have on contractors. Depending on prescribing behaviours within a particular area, this change may result in an inequitable distribution of margin between contractors. This proposal should not increase the risk to contractors of dispensing at a loss. Consideration would also need to be given to both the availability and the prices at which Northern Ireland contractors can access these medicines. Information sources that are predominantly or entirely based on English prices should not be applied to Northern Ireland without taking into account the prices and volumes at which such products are available to the Northern Ireland market.

Proposal 4 - Changes to the deduction scale to reflect different levels of discount for branded and generic medicine

Q8 Do you agree with this proposed reform?

~~Yes~~ **No** ~~Don't know/no views~~

Q9 Do you have any comments on this proposed reform?

CPNI welcomes the opportunity to discuss changes to the deduction scale to reflect different levels of discount for branded and generic medicines. Prior to 2011, Northern Ireland had two separate deduction rates for branded and generic medicines. In 2010/11, the last year that a dual discount rate was applied, approximately £23m was removed as discount. In 2011/12, the first year of a single discount rate being applied, approximately £34m was recovered. This single action alone effectively removed more than £10m from the community pharmacy economy in 2011/12 alone.

Any subsequent changes to the discount recovery scale should be carefully considered, and the impact measured. CPNI welcomes the consideration being given to a dual discount deduction scale to reflect generic and brand medicines but would disagree with a likely scenario that is being considered by DHSC to introduce a lower deduction scale for brands and a higher rate for generics that is modelled in order to arrive at the same overall level of clawback being recovered. Any assertion that doing so would be fairer to those contractors dispensing higher levels of brand medicines relative to generic medicines is an inherent admission that the current arrangements are unfair and disadvantage Contractors in this grouping. CPNI is of the view that the fundamental issues within the Northern Ireland Drug Tariff need to be addressed; adjustments should be made to reflect Northern Ireland factors, as has been done in Scotland, so that the overall funding the NIDT is set to deliver provides sustainable, fair and reasonable remuneration to all contractors. CPNI would appreciate the opportunity to engage in discussions as to how an appropriate dual discount rate could be introduced.

PART B- Equality and Human Rights

Section 75 of the Northern Ireland Act 1998 requires departments in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity:

- between persons of different religious beliefs, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between person with a disability and persons without; and
- between persons with dependents and persons without.

In addition, without prejudice to the above obligation, Departments should also, in carrying out their functions relating to Northern Ireland, have due regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

In accordance with guidance produced by the Equality Commission for Northern Ireland and in keeping with Section 75 of the Northern Ireland Act 1998, the Framework has been equality screened and a preliminary decision has been taken that a full Equality Impact Assessment (EQIA) is not required. Departments also have a statutory duty to ensure that their decisions and actions are compatible with the Human Rights Act 1998 and to act in accordance with these rights.

Q10. Do you consider that any of the proposals contained in this consultation document would have an adverse impact on any of the nine equality groups identified under Section 75 of the NI Act 1998? If yes, please state the group(s) and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.

Yes ~~No~~

Comments:

CPNI would suggest that a Northern Ireland specific impact assessment will be necessary to ensure that no patient groups in any area of Northern Ireland will be adversely impacted by the adoption of these proposals.

Q11. Are you aware of any indication or evidence – qualitative or quantitative – that the proposals set out in the consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Yes ~~No~~

CPNI would suggest that a Northern Ireland specific impact assessment is necessary to provide evidence to ensure that no patient groups in any area of Northern Ireland will be adversely impacted by the adoption of these proposals. The absence of an impact assessment makes it extremely difficult, if not impossible, to safeguard against an adverse impact on equality of opportunity or on good relations.

Q12. Is there an opportunity to better promote equality of opportunity or good relations among any of the nine equality groups identified under Section 75 of the NI Act 1998? If yes, please give details and comment on how the Department could better promote equality of opportunity or good relations among the group or groups you have identified

Yes ~~No~~

Comments

CPNI would suggest that a Northern Ireland specific impact assessment is necessary to ensure that no patient groups in any area of Northern Ireland will be adversely impacted by the adoption of these proposals. This would provide a basis on which to better promote equality of opportunity or good relations among patient groups.

Q13. Are there any aspects of the proposals where potential human rights violations may occur?

Yes ~~No~~

Comments:

CPNI would suggest that a Northern Ireland specific impact assessment is necessary to ensure that no patient groups in any area of Northern Ireland will be adversely impacted by the adoption of these proposals and that no potential human rights violations occur.

Rural Impact

The Rural Needs Act (NI) 2016 places a duty on public authorities, including government departments, to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services.

A draft rural needs impact assessment has been prepared and is available on the Department's website.

Q14. Are the actions/proposals set out in this consultation document likely to have an adverse impact on rural areas?

Yes ~~No~~

If yes, please provide comment on how these adverse impacts could be reduced or alleviated.

Rural areas may have reduced access to medicines and suppliers, a reduced frequency of deliveries and different prescribing behaviours to more urban areas. These factors should be considered when mitigations are being looked at to ensure contractors, and ultimately patients, in these areas are not disadvantaged when any changes are introduced.

Thank you for your comments.