

Completion of the Recovery Strategy

We are pleased to report that the PPA's recovery strategy to clear the prescription backlog has been successfully achieved. The processing of August 2001 dispensed prescriptions was completed on 11th October at which time the backlog was cleared entirely. The processing of September prescriptions was completed on 30th October and normal service levels have been resumed. Subsequent months prescriptions will be processed within a monthly cycle.

Clearing the backlog means that payments to all dispensing contractors/doctors will now return to normal. To provide an outline:

Payments to pharmacy contractors on 1st November comprised:

The value of the July schedule, plus the value of the August schedule, less the 100% interim payment made on 1 October, together with any payments authorised by the Health Authority.

Payments to pharmacy contractors on 30th November have returned to normal and comprised:

The value of the September schedule (comprising the 20% balance for September prescriptions plus the 80% advance payment for October prescriptions), together with any payments authorised by the Health Authority.

As readers will be aware the prescription backlog arose as a result of generic drugs shortages, outside the direct influence of the PPA. The effect was significant on the PPA's prescription processing activity. As the volume of generic items included in Part VIII of the Drug Tariff increased, this had a cumulative impact on the backlog. At its peak this amounted to three months, in the region of 150 million unprocessed prescriptions.

Our recovery strategy has involved a number of strands. For dispensing contractors it involved the creation of a system to pay 100%

interim amounts which ensured that a regular payment was received each month. Internally PPA Operations processing divisions temporarily recruited more staff, split the data capture business process into component parts to enable faster training of new entrants, and designed new training programmes. These initiatives have resulted in the backlog being cleared and should provide more flexibility to deal with significant variations in work volume or levels of complexity in the future.

When our recovery strategy was drawn up, we forecast that the backlog could be cleared with the processing of August 2001 dispensed prescriptions and that this could be achieved by the end of September 2001. Our forecast was based on dealing with the normal 3.5% annual growth in prescription volume.

Readers may be aware that the increase during the last financial year was in excess of 5% and intake for this financial year is currently in excess of 5%. We are therefore pleased that the recovery has been achieved within a few days of the original target, despite dealing with a much higher prescription intake.

We fully appreciate the problems caused to all stakeholders as a result of the delays to our service and would like to thank you for your continued support during this difficult period. It is pleasing that the considerable efforts of PPA staff and managers have now resulted in the clearance of the prescription backlog.

CONTENTS

In this December 2001 edition read about:

The Recovery Strategy Completion of the PPA's Recovery Strategy.	PAGE 1
Electronic Transmission of Prescriptions An update of progress.	PAGE 2
The PPA Annual Public Meeting	PAGE 3
PACT Centre Pages Cardiovascular Prescribing – the patterns and trends of prescribing.	PAGE 4/5
Introduction to the Primary Care Drug Dictionary for NHS in England Details of the project initiated by the Department of Health	PAGE 6
NHS Modernisation Agency	PAGE 6
Dispensing and Reimbursement Hints and Tips Reminders of recent changes that might affect reimbursement.	PAGE 7
Nurse prescribing – Nicotine Replacement Therapy Guidance on prescribing.	PAGE 7
imPACT Customer Satisfaction Survey	PAGE 7
BACS Payment Dates 2002 Dates 2001/2002 for pharmacy contractors, appliance contractors and oxygen concentrator payments.	PAGE 8
PPA ePACT.net Training Courses Details of future courses.	PAGE 8

ELECTRONIC TRANSMISSION OF PRESCRIPTIONS (ETP) UPDATE

The preparation for the ETP pilots is underway to enable the transmission of prescription data between GPs, Pharmacists and PPA. The three pilot consortia of Pharmacy2U, Sema and TransScript are implementing three different business models (as described the June 2001 issue of this magazine) that will be evaluated by an independent team. This will inform the business case on how to best roll out ETP across the NHS. It is expected that this rollout will start in 2004

Testing Activities

The pilot project is now moving to the testing phase. When this is completed the PPA will start to make payments to dispensing contractors based upon the electronic messages.

It is therefore ESSENTIAL that all interfacing computer systems transmit complete information with an accuracy level which equates to or improves the accuracy level currently achieved.

Testing will be conducted in a number of stages to ensure that the systems are robust and address the fundamental requirements. This will complement the formal training for the personnel involved in the operation of those systems.

The first stage of testing being carried out is Alpha testing. The objective is to test the integration and exchange of messages between the PPA and the GP and Pharmacy system suppliers. Alpha testing will test that both the structure and content of the message is valid and the security features are operating effectively.

The second stage of testing is Acceptance testing. The objective is to ensure that each Dispensing Contractor in the pilot can

produce messages from their systems which reflect the quality and accuracy required to enable timely and accurate reimbursement and provision of prescribing and dispensing information.

The members of the pilots will provide the PPA with a test pack of electronic messages and the associated patient declaration forms. The electronic messages will be processed through the PPA's computer systems. The output will be measured against predetermined acceptance criteria that have been designed to determine their acceptability for payment purposes and that the exemption identified on the patient declarations form is consistent with the declaration in the ETP message.

The final stage of testing is Beta testing. The objective is to commence the transmission of messages in a live environment. This will involve a small sample of GPs and dispensing contractors from each consortium who have successfully completed the acceptance testing. It is planned that Beta testing will commence in December 2001.

Adding more GPs and dispensing contractors to the Beta test will be subject to agreement between the PPA and each consortium.

Security of Information

To successfully realise the full potential of electronic transmission of prescription messages it is necessary to enable at least a comparable level of security that is associated with paper-based transactions.

In the digital environment, a **Public Key Infrastructure (PKI)** ensures that sensitive electronic communications are private and protected. It provides assurances in the identities of the participants in those

transactions, and prevents their later denying participating in the transaction.

In the ETP pilot environment the PKI will:

- protect privacy by ensuring that electronic communications are not intercepted and read by unauthorised persons
- assure the integrity of electronic communications by ensuring that they are not altered during transmission
- verify the identity of the parties involved in an electronic transmission
- ensure that no party involved in an electronic transaction can deny their involvement in the transaction

The Certification Authority is a main component of the PKI. It is a trusted third party responsible for issuing digital certificates and managing them throughout their lifetime. Digital certificates are electronic files containing the user's public key and specific identifying information about the user. They are tamper-proof and cannot be forged. Much as a passport office does in issuing a passport, a Certification Authority certifies that the individual granted the digital certificate is who he or she claims to be.

PKI is the technology being adopted in the ETP pilots. The three pilot consortia are employing different PKI solutions all of which offer the assurances of secure and confidential transmission of information.

Additional security is provided by the use of NHSnet, the NHS's own private network, and the PPA firewalls where only authorised users can obtain access.

Further information on the ETP pilot project can be found on the PPA websites (www.ppa.nhs.uk and www.ppa.org.uk).



THE PPA ANNUAL PUBLIC MEETING

The PPA's annual public meeting was held on 30 October 2001, at the Royal College of Pathologists in London.

Pharmacists, GPs, Pharmaceutical Advisors and others representing a broad spectrum of healthcare interests attended the meeting. They were welcomed by outgoing PPA Chairman, Professor David Johns, who emphasised that the PPA remains committed to working with stakeholders to provide a range of effective and valued products and services.

The meeting provided an opportunity for stakeholders to:

- receive information on the PPA, covering its Annual Report and accounts for 2000-2001;
- see demonstrations of the PPA's information services and products including ePACT.net and the Prescribing Toolkit; and
- meet and question the PPA's executives and non-executives.

A series of presentations explored changes that are affecting the whole of the NHS from the perspective of the challenges and improvements that will shape the PPA in the future.

Christine Dalton, Director of Pharmaceutical Policy and Services, examined the factors influencing growth and complexity in our processing activities.

She explained the drivers for the changes in volume growth. National Service Frameworks and increasing standardisation on '28 day' monthly prescriptions are both factors. Growth, which was for a long time steady at around 3.5% a year, rose to 5% in the twelve months to March 2001 and is currently projected to rise as high as 7% over the next year.



The PPA's response to this growth and to the increased complexity of processing associated with initiatives, such as extended nurse prescribing, flowing from *Pharmacy in the Future*, is to develop and adapt the flexibility which was introduced to successfully handle the recovery from the Category D backlog.

Douglas Ball, Director of Information Technology, built on this with an exploration of two distinct Department of Health policy initiatives which are challenging the PPA to provide new and better services across the NHS.

The first of these – Electronic Transmission of Prescriptions – is a familiar topic for imPACT. The three consortia models were explored together with the development work that continues within the PPA to advance systems to accept three forms of Public Key Infrastructure, system to image and translate paper prescriptions and a new rules engine to automatically process electronic messages. Douglas also explained the PPA's role in working to develop new standards for messages and a drug dictionary. He also set out the principles behind the PPA's testing strategy both for our own system developments and the interfaces we are developing for the messages coming from each ETP pilot.

The second major challenge is to adapt the PPA's information services to the changing NHS structures foretold in *Shifting the Balance of Power*. This will shift the emphasis of a number of PPA products away from the existing 95 Health Authorities towards the emerging 350 or so PCTs.

PPA Chief Executive, Nick Scholte, rounded off the presentations by linking the themes of the first two in an explanation of the Category D recovery, recent developments within the PPA and our focus for enhancement over the coming year.

The meeting heard that the PPA's services are back on schedule and we have entered a fresh year keen to re-evaluate and re-engineer our products and services to stakeholders to maximise the benefits to them and to improve the value of our services to consumers.

Over 30 representatives of healthcare organisations were present, making this the PPA's most successful public meeting to date. A copy of the presentations made to the meeting and a note of the proceedings including the question and answer session are available on the authority's Web and NHSnet sites. A number of comment forms were returned and these are being analysed to support the planning of next year's meeting, which we hope will be even bigger and better.

MEMBERSHIP OF THE AUTHORITY



PPA Chair - Ann Galbraith

Health Minister Hazel Blears announced the appointment of Anne Galbraith as Chair of the PPA at the start of November.

Hazel Blears said: "Anne Galbraith has extensive experience of the NHS and the voluntary sector which makes her particularly well suited to lead the PPA through what will be a period of significant change. The development of electronic prescribing will present many challenges and opportunities for the PPA, as will the implementation of our programme for pharmacy set out in *"Pharmacy in the Future"*. I would also like to thank Mrs Galbraith's predecessor, Professor David Johns for his hard work at the PPA over the last few years."

Mrs Galbraith is an existing member of the Authority, to which she was appointed last year. By profession, she is an academic lawyer. She was Chairman of the Royal Victoria Hospitals NHS Trust, Newcastle from 1990 to 1997, and a member of the Northern Regional Health Authority from 1988 to 1991. She is a member of the Council on Tribunals and of the Council of the University of Durham. She has been involved with the Citizens Advice Bureaux movement for many years, and undertakes a range of other voluntary and charitable activities.

This appointment follows the addition of Mike Ramsden to the Membership of the Authority in September. He is Chief Executive of Leeds Health Authority and replaces Peter Catchpole, formerly Chief Executive of West Sussex Health Authority.

PACT CENTRE PAGES – CARDIOVASCULAR PRESCRIBING

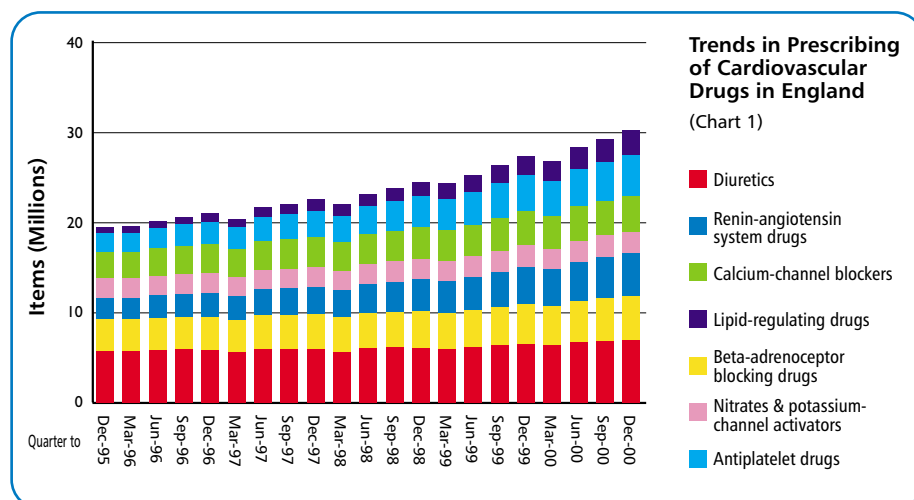
The PACT Centre Pages report on Cardiovascular Prescribing, issued to General Practitioners in July 2001, is reproduced here for readers with an interest in patterns and trends of prescribing.

The burden of coronary heart disease (CHD) is higher in the UK than in many other countries. More than 110,000 people die from CHD in England every year, of whom 41,000 are aged under 75 years. About 300,000 people in the UK have heart attacks every year and over 1.4 million suffer from angina. CHD accounts for about 3% of all hospital admissions in England. Angina, heart attack and stroke are all more common amongst those in manual social classes. There are also ethnic variations, for people born in the Indian sub-continent, the death rate from heart disease is 38% higher for men and 43% higher for women than rates for the country as a whole.

The National Service Framework (NSF) for Coronary Heart Disease sets out the standards and services that should be available throughout England. It recognises the importance of prevention and primary care as well as the contribution of the more specialised services. The NSF establishes 12 standards for the prevention, diagnosis and treatment of CHD. In order to deliver these standards a variety of measures are included in the NSF, for example:

- local delivery plans reflected in Health Improvement Programmes and long term service agreements.
- PCG/Ts, NHS trusts and health authorities forming local networks of cardiac care and agreeing referral criteria and care pathways. Milestones have been identified for each standard that are intended to foster a process of continuous improvement. Examples of milestones and goals for primary care include:
- by April 2002 a protocol describing the systematic assessment, treatment and follow-up of people with CHD has been agreed locally and is used to provide structured care to people with CHD
- by April 2003 clinical audit data, no more than 12 months old, is available that describe the use of relevant effective interventions in angina and heart failure.

Standard 5 of the NSF for Older People includes approaches that aim to reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services. Prevention of stroke depends on reducing risk factors for the population as a whole as well as those at greatest risk. The main risk factors for stroke are cardiovascular disease, metabolic disease (diabetes, hyperlipidaemia and obesity) and lifestyle (alcohol misuse, poor diet, low level of physical activity and smoking). The risk of stroke for people with hypertension can be reduced by 37% through appropriate treatment. By April 2004 PCG/Ts will ensure that every general practice



- advice about how to stop smoking (inc. NRT)
- information about other modifiable risk factors
- advice and treatment to maintain blood pressure below 140/85 mmHg
- low dose aspirin (75mg daily)
- statins and dietary advice to lower serum cholesterol concentrations to either less than 5mmol/l or by 30% (whichever is greater)
- ACE inhibitors for people who also have left ventricular dysfunction
- beta-blockers for people who have also had a myocardial infarction
- warfarin or aspirin for people over 60 years old who also have atrial fibrillation
- meticulous control of blood pressure and blood glucose in people who also have diabetes

A NICE Clinical Guideline⁴ makes recommendations for patients who have experienced a myocardial infarction (MI) and has the aim of decreasing subsequent premature mortality. Patients with prior MI who do not have heart failure should be offered long-term treatment firstly with a beta-blocker and an antiplatelet drug (aspirin) and then with a statin and an ACE inhibitor. Calcium-channel blockers, nitrates and potassium-channel activators have no effect on premature mortality making their role the management of symptoms and risk factors (principally hypertension). Patients with prior MI and heart

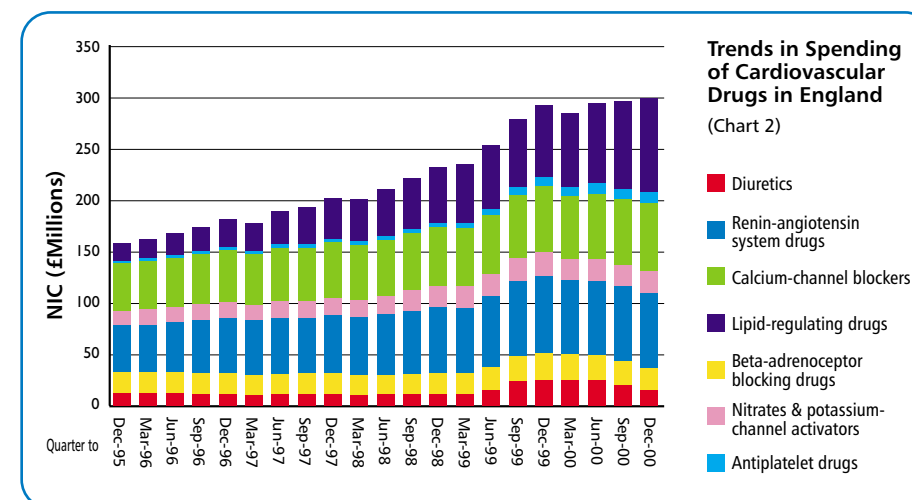
can identify and treat patients identified as being at risk of stroke because of hypertension, atrial fibrillation and other risk factors.

People with established cardiovascular disease and others at high risk of a future cardiovascular event should be identified and offered advice and treatment. Two recent MeReC Bulletins^{1,2} describe in detail the approach to cardiovascular risk assessment and the risk assessment tools recommended in the NSF for CHD. Risk assessment tools should not be used for people with pre-existing cardiovascular disease. The Joint British Societies Coronary Risk Prediction charts can also be found at the back of the current BNF.

Supporting smokers who wish to stop is an immediate priority. Bupropion (amfebutamone) and nicotine replacement therapy products (NRT) are now available on NHS prescription. The Committee on Safety of Medicines has recently alerted prescribers to the modified dosage and safety precautions for bupropion to minimise the risk of adverse effects and reduce the risk of seizure³. Prescribing of bupropion has increased gradually since its introduction in summer 2000, reaching 114,000 prescriptions for the quarter to December 2000 costing £4.5 million. NICE will publish an appraisal of NRT and bupropion later this year. From April 2001 nurse prescribers have also been able to prescribe NRT.

ITEMS (to nearest thousand)

	Quarter to Dec 95	Quarter to Dec 00
Thiazides & Related diuretics	1,799,000	3,276,000
Loop diuretics	1,513,000	2,385,000
Potassium sparing diuretics with other diuretics	221,000	298,000
Thiazides & Related diuretics	1,938,000	1,166,000
Thiazides & Related diuretics	177,000	64,000



failure should be offered long term treatment with an ACE inhibitor and then a beta-blocker. Beta-blocker treatment should be started at low doses and should be slowly increased. In addition these patients should be treated with an antiplatelet drug. Those patients who have moderate or severe heart failure should also be treated with spironolactone.

Prescribing of cardiovascular drugs reached 34.0 million prescriptions (£329.8 million) for the quarter to December 2000. Prescribing of lipid-regulating drugs, antiplatelet drugs and renin-angiotensin system drugs (Chart 1) has shown the greatest increase. Not surprisingly cost has also risen (Chart 2): more is now spent on lipid-regulating drugs and renin-angiotensin system drugs than any other cardiovascular drugs. The following prescribing data are given for the quarter to December 2000 unless otherwise indicated

Diuretics are the most commonly prescribed group (7.2 million prescriptions per quarter). Over the last five years prescribing of combination products has decreased whilst prescribing of single diuretics has increased (see table). Bendrofluzide and frusemide are the most commonly prescribed diuretics (3.1 and 2.1 million prescriptions per quarter respectively at a cost of £3.6 million and £2.9 million). The ratio of prescriptions for 2.5:5 mg bendrofluzide has risen to 7:1 from 2:1 five years ago. Spironolactone is now the most commonly prescribed single potassium sparing diuretic, however amiloride is most frequently prescribed in combination products. Prescribing of spironolactone was falling until 1999 but by the quarter to December 2000 prescriptions had increased by 115% to 183,000 per quarter. This change follows the publication of the Randomized Aldosterone Evaluation Study⁵ that showed, in patients with severe heart failure, addition of 25mg spironolactone to conventional treatment significantly lowered the risk of death from progressive heart failure and sudden death.

Beta-blockers - 64% of prescriptions for beta-blockers are for atenolol (3.1 million per quarter) but it is just 24% of cost (£4.8 million per quarter). Beta-blockers that are licensed for the treatment of heart failure account for only a small proportion of beta-blocker prescriptions e.g. bisoprolol (6%) and carvedilol (0.6%).

Drugs affecting the renin-angiotensin system - there were 4.0 million prescriptions for ACE inhibitors in the quarter to December 2000 costing £53.4 million. Most often prescribed are lisinopril (34% of prescriptions), enalapril (23%) and ramipril (18%). Use of angiotensin-II receptor antagonists continues to grow and they now account for 738,000 prescriptions (£19.6 million) per quarter.

Calcium-channel blocker prescribing has increased by 34% to 4.1 million prescriptions (£66.2 million) per quarter. This is despite concerns that they may increase the risk of cardiovascular events, cancer and suicide. Recent trials and meta-analyses have provided some evidence that there may be no difference in total or cardiovascular mortality between calcium-channel blockers and other antihypertensive drugs⁶. Larger trials are required to provide a definitive answer. Amlodipine is most frequently prescribed (1.5 million prescriptions) followed by nifedipine (1.1 million).

Nitrates and potassium-channel activators - prescribing of nitrates has hardly changed in the last five years (around 2 million prescriptions per quarter). Isosorbide mononitrate continues to be most commonly prescribed (62% of nitrate prescriptions and 79% of costs). To avoid tolerance isosorbide mononitrate should be prescribed either as modified release formulation once daily or conventional release formulation twice daily using asymmetric dosing. Prescribing of nicorandil has increased to 241,000 prescriptions (£2.7 million) per quarter.

Oral anticoagulants and Antiplatelet drugs - 99% of anticoagulant prescriptions are for warfarin: 1.1 million per quarter (£3.9 million). Prescribing of low-dose aspirin is still rising. Although 93% of antiplatelet prescriptions are for aspirin (4.1 million per quarter), this only represents 37% of antiplatelet cost (£3.5 million per quarter for aspirin). Clopidogrel accounts for 39% of cost but only 2% of prescriptions whilst dipyridamole is 20% of cost and 4% of prescriptions.

Lipid-regulating drugs - statins account for 92% of prescriptions for lipid-regulating drugs (2.7 million per quarter) and 95% of cost (£87.1 million per quarter). Their prescribing has increased 7-fold in the last five years. Simvastatin is the most commonly prescribed statin (43%) followed by atorvastatin (32%).

References

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2. Anonymous. Assessing cardiovascular risk (part 2). MeReC Bulletin 2000; 11: 29-32
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6. C Mulrow & R Jackson. What are the effects of drug treatment in primary hypertension? Primary Prevention, Clinical Evidence Issue 4, BMJ Publishing Group, Dec 2000: 66-69

The NSFs can be found on the following website - www.doh.gov.uk/nsf

This Centre Pages article can also be found on the PPA website - www.ppa.nhs.uk

SUMMARY

More than 110,000 people die from CHD in England every year

By April 2002 a locally agreed protocol for systematic assessment, treatment and follow-up must be in use to provide structured care to people with CHD

By April 2004 PCG/Ts will ensure that every general practice can identify and treat patients at risk of stroke

Beta-blockers, aspirin, statins and ACE inhibitors are first choice for patients with prior MI but no heart failure

Spironolactone is of benefit in patients with moderate or severe heart failure

INTRODUCTION TO THE PRIMARY CARE DRUG DICTIONARY FOR NHS ENGLAND

The Department of Health has recently initiated a project for the creation of a drug dictionary that will be used as a cornerstone for the Electronic Transmission of Prescriptions, the automation of business processes within the PPA and ultimately for use in Primary Care across the NHS in England. The range of products that the dictionary will reference include:

- all drugs which are prescribable and reimbursable within primary care,
- NHS black listed products,
- appliances and reagents that are listed in the Drug Tariff issued by the NHS for England and Wales.

The above include most of the medicinal products in the PPA Product List and they constitute over 99.9% of prescribed and dispensed medicinal products within primary care. The aim is not to be so exhaustive as to include every possible product and it will be left to editorial policy to decide on the inclusion of rarely issued items.

The completion of the project will support the business processes shown in the figure below:

Benefits from the use of a drug dictionary for primary care include:

- common drug data will be used in the prescribing and dispensing processes and in the transfer of prescriptions between GPs, dispensers and the PPA.
- openness in the reimbursement and remuneration process undertaken by the PPA.
- increased automation of the prescription processing processes undertaken by the PPA and a minimisation of manual intervention in those processes.
- a reduction in the number of situations where queries regarding data content are raised relating to prescribing, dispensing and processing.

Working with a team of GP, Pharmacy and NHSIA stakeholders co-ordinated by the Sowerby Centre for Health Informatics at Newcastle (SCHIN) the PPA will develop and populate the dictionary by the end of December 2002. This will enable GP and pharmacy system suppliers to integrate it into their systems throughout 2003 in readiness for the introduction of electronic prescriptions into the community which is planned to start in 2004.



NHS MODERNISATION AGENCY

From 1 October, the PPA began to provide a range of financial and Human Resources services for the NHS Modernisation Agency.

The Agency has an important role to play in supporting the transformation of the NHS. The movement for modernisation is growing rapidly. Currently, the Agency is working with more than 1,000 local project teams in important work such as:

- improving access to primary health and social care services
- promoting safe, effective and high quality care through clinical governance
- redesigning patient journeys for those needing cancer, coronary heart disease and critical care services.

The Agency is also supporting more than 30,000 leaders and managers in the service to develop to their full potential. Many thousands of staff across the NHS are currently modernising their services.

The Agency was formally created in April, and was an amalgamation of several on-going projects. The largest of these is the National Patient Access Team, based in Leicester, which is a group dedicated to finding ways of making health services more focused to the needs of patients. Another part of the Agency runs the NHS Leadership Centre, which concentrates on the training and development of future Board Level Directors and Chief Executives. Recently the Agency was asked to review the position of the 12 NHS Trusts who received no stars under the newly introduced performance evaluation system.

Overall, there are over 200 NHS staff employed by the Agency, many of them seconded from other Health organisations and there is a substantial volume of financial transactions associated with the numerous development courses that they run.

The PPA has recruited additional staff to cope with the increased workload and will integrate support within the existing PPA services to ensure that efficiencies are achieved. HR services include assistance in advertising, recruitment and selection of staff and advice on terms and conditions. Finance services include payroll, pensions, payment of expenses and accounts, the raising of invoices to participants at training events, and accountancy and management accountancy support.

The PPA was able to demonstrate that it could offer a quality and cost-effective service, and was selected as the best choice among those that tendered for the service. We look forward to working with the Agency for many years to come.

HINTS AND TIPS DISPENSING & REIMBURSEMENT

- For information - Roche Diagnostics have discontinued Glucotrend Plus test strips and are now marketing a slightly different product (Active test strips). You are reminded that Glucotrend Plus were deleted from Part IXR of the Drug Tariff from 1st December therefore from that date prescriptions ordering Glucotrend Plus will be disallowed for payment. You can **not** dispense Active against a prescription for Glucotrend Plus without the prescription being amended by the prescriber.
- Please note - Medisense Auto lancets are not included in Part IXA of the Drug Tariff therefore prescriptions ordering this item will be disallowed.
- Still on the topic of diagnostic products - we have been advised by Roche Diagnostics that all of their diagnostic products (lancets, testing strips etc) are now marketed under the Accucheck label yet also retain their own branding. Thus the packaging for Softclix lancets will show "Accucheck Softclix lancets" on the box; similarly Advantage II biosensor strips will appear as "Accucheck Advantage II" etc. You may find that a doctor will prescribe an "open" order such as Accucheck lancets, Accucheck reagent strips. If this happens, you need to endorse which Drug Tariff item you have supplied in order that we can reimburse you correctly.
- Please note - Apomorphine Hydrochloride (Uprima) was added to Schedule 11 to the National Health Service (General Medical Services) Regulations 1992 from 1st November 2001 in England. This brings this item into line with other drugs for the treatment of erectile dysfunction therefore the doctor must endorse the prescription with the reference "SLS" before you can dispense it.
- For information - we are often asked whether prescriptions for Glucosamine tablets will be allowed. There is an entry in "the blacklist" for Health Perception Glucosamine tablets therefore you will not be reimbursed if you dispense that brand.
- A reminder - there have been a number of minor amendments over the last few months to the list of items which can be prescribed by a qualified nurse prescriber;
 - nurses can now prescribe Chlorhexidine gauze tulle dressings
 - nurses are unable to prescribe calamine preparations (Calamine Lotion BP, Oily Calamine Lotion BP and Aqueous Calamine Cream BP)
 - nurses can now prescribe the emollient preparations Cetraben and Doublebase
 - the Nurse Prescribers Formulary now more accurately reflects the actual items which nurses can prescribe when treating patients who hope to "give up smoking"
- Please note - Luborant is the only branded product that meets the Dental Practitioners' Formulary formula for Artificial Saliva. There are, however, long-term supply difficulties with Luborant therefore if you receive a Form FP10D ordering Artificial Saliva you will need to either dispense extemporaneously or have the formula made up by a "specials laboratory".

NURSE PRESCRIBING - NICOTINE REPLACEMENT THERAPY

Guidance on the items currently prescribable by nurse prescribers at NHS expense can be found in the Drug Tariff Part XVIIIB. Changes are normally published through an advanced notification in the preface at the front of the Drug Tariff.

The current Nurse Prescribers' Formulary has evolved over the last year and since May 2001 over 20,000 qualified district nurses and health visitors have been able to prescribe nicotine replacement therapy (NRT) products such as nicotine patches, gum and inhalers. From November 2001, the generic entry of Nicotine Replacement Therapy Products in Part XVIIIB of the Drug Tariff has been replaced with a more detailed version:

- Nicotine Inhalation Cartridge for Oromucosal Use, NPF
 - Nicotine Lozenge, NPF
 - Nicotine Medicated Chewing Gum, NPF
 - Nicotine Nasal Spray, NPF
 - Nicotine Sublingual Tablets, NPF
 - Nicotine Transdermal Patches, NPF
- Prescriber should specify brand and strength to be dispensed.

- Releasing nicotine over 16 hours:
 - Nicorette Patches
- Releasing Nicotine over 24 hours:
 - Boots NRT Patches
 - NiQuitin CQ Patches
 - Nicotinell TTS Patches

These changes give patients quicker access to the help they need. They will also help make better use of the skills of a number of nurse prescribers who run smoking cessation clinics and are another important building block in developing a comprehensive smoking cessation service.

Nurse prescribers are being guided to prescribe the Nicotine Transdermal Patches, NPF by a specific brand and pharmacists should seek clarification from the prescribers in the absence of a brand indication.

ImPACT CUSTOMER SATISFACTION SURVEY

The editorial board would like to thank all who have returned the customer satisfaction survey form from the September edition. We are analysing the results and will publish them in a future edition of "imPACT". If anyone still wishes to return a questionnaire, please do so as quickly as possible.

BACS PAYMENT DATES 2002

The following table highlights payment dates for 2002 for pharmacy contractors, appliance contractors and oxygen concentrator payments.

Pharmacy Contractors	Appliance Contractors	Oxygen Concentrator
30 November 2001	30 November 2001	09 November 2001
31 December 2001	31 December 2001	11 December 2001
01 February 2002	01 February 2002	10 January 2002
01 March 2002	01 March 2002	11 February 2002
02 April 2002	02 April 2002	11 March 2002
01 May 2002	01 May 2002	10 April 2002
31 May 2002	31 May 2002	10 May 2002
01 July 2002	01 July 2002	13 June 2002
01 August 2002	01 August 2002	09 July 2002
30 August 2002	30 August 2002	09 August 2002
01 October 2002	01 October 2002	10 September 2002
01 November 2002	01 November 2002	09 October 2002
29 November 2002	29 November 2002	11 November 2002
31 December 2002	31 December 2002	10 December 2002

Pharmacy & Appliances - based on 1st of month or nearest prior working day - except in April which is 1st or nearest later working day.
Oxygen - based on 7th working day

PPA ePACT.NET COURSES

These courses have proven to be extremely popular and feedback has been very positive.

Examples include:

"Presenters knowledge excellent"

"Excellent course"

"Training facilities excellent"

"Lots of hints and tips good to be able to practice using own data."

There are currently two ePACT.net courses available basic and intermediate. The duration of each course is one day and they run on consecutive days. The basic course is designed for HA and PCG/T prescribing advisors and analysts who have little or no experience of the system wishing to use ePACT.net to analyse PCG/T prescribing. The intermediate course is for HA and PCG/T prescribing advisors who already have some practical experience of ePACT.net but wish to make full use of the system to analyse prescribing in depth.

A maximum of nine delegates can be accommodated per course with each delegate receiving full hands on training. Delegates will be using their own prescribing data for the majority of the course, enabling them to create and save custom tags, graphs and reports on their own system. Although previous knowledge of the system is not necessary for the basic course delegates should have a working knowledge of Windows applications.

The Basic course content includes:

- Explanation of prescribing terminology and prescribing measures.
- Basic navigation - selecting and applying data.
- Tagging.
- Graphing.
- Report Expert.
- How to print and save graphs and reports.

On completion of the basic training you should be able to:

- Select and apply data.
- Create tags.
- Produce basic reports and graphs.
- Perform routine prescribing tasks.

The Intermediate course content includes:

- Revision of basic ePACT.net functions.
- Creating custom graphs and reports.
- Techniques to minimise processing time.
- Exporting data from ePACT.net.
- Basic manipulation of ePACT.net in spreadsheets.

On completion of the intermediate training you should be able to:

- Create complex tags.
- Produce custom reports and graphs.
- Analyse prescribing.
- Receive information on high cost drugs.
- Produce budget information.
- Detect abnormal prescribing (e.g high opiate prescribing).

Training course dates

ePACT.net Basic

4th December, 8th January, 15th January,
12th February, 5th March, 19th March

ePACT.net Intermediate

5th December, 9th January, 16th January,
13th February, 6th March, 20th March

Provisional booking by telephone is recommended to ensure availability.

Bookings can be made on-line on our website or by post. The latest information can be found on our NHS Net Site, www.ppa.nhs.uk or be obtained by contacting Training@ppa.nhs.uk or telephoning 0191 2035040.