



# imPACT

Prescription Pricing Authority Newsletter

## Patient Services:

# Helping patients to pay for their healthcare

You may not be aware, but the PPA has been around as a Special Health Authority (SpHA) longer than most - we trace our roots back to 1911. Most importantly, we look after the *Help with health costs* schemes available to the public throughout the country.

Formerly known as the Health Benefits Division (HBD) at the PPA, we will be relaunching the schemes under the new umbrella of Patient Services.

Pharmacists, GPs, Nurses and those involved in front line primary care are one of our key stakeholder groups and offer one of the most effective ways of educating and communicating with the public about their entitlements.

The services we offer are summarised as follows:

### The Low Income Scheme (LIS)

The LIS helps people on a limited income with a range of NHS health costs. The scheme compares an individual or family's income with their needs, to calculate whether they should receive free or reduced cost NHS treatment. The assessment follows broadly the same rules as those used to assess income support and housing benefit, but also considers weekly expenditure for rent/mortgage and council tax.

Anyone who has capital of £8,000 or less can apply (£12,000 for people aged 60 or over). People who qualify will be sent either form HC2 entitling them to free NHS treatment or form HC3 entitling them to reduced cost treatment. Claims are made on form HC1 obtainable from Patient Services.

### Prescription Pre-Payment Certificate (PPC)

These certificates are available to reduce the costs of prescription for anyone who needs more than 5 items on prescription in a 4 month period, or 14 items in a year. They cost £33.40 for a 4 month certificate and £91.80 for a year, from April (see page 2). There are now a number of ways to purchase a certificate:

- By post using form FP95.
- Online via the PPA website.
- Using the telephone orderline 0845 850 0030.
- From a number of local pharmacies which sell certificates on behalf of the PPA (see website).

These certificates can be used for all prescription charges incurred during the period of the certificate, no matter how many charges are incurred. Therefore, they can result in considerable savings for those people who obtain a large number of prescription items.

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**NHS**

Prescription Pricing Authority



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# Patient Services

## Medical Exemption

People who suffer from one of a specific list of medical conditions may apply for a certificate which will provide exemption from prescription charges. The conditions listed include:

- Diabetes controlled by medication.
- Epilepsy requiring continuous anti-convulsive therapy.
- Hypoparathyroidism.

To view the full list, you should pick up leaflet HC11 available from main Post Offices or visit the PPA website. People who suffer from any of the listed conditions should fill in a form at their GP surgery; this will then be forwarded to Patient Services and a small credit card certificate will be issued that is valid for 5 years.

## Maternity Exemption Certificates

These are issued to pregnant women and those who have given birth in the last 12 months. Applications should be filled in by the GP, midwife or health visitor and signed by the patient. The form will be posted by the surgery to the PPA. A small plastic card will be issued and it is valid until 12 months after the expected or the actual date of confinement.

## NHS Credit Exemption

Certain people who receive working tax credits and child tax credits are also exempt from NHS charges. Patient Services issue NHS Tax Credit Exemption Certificates on behalf of the Inland Revenue to those entitled to them.

## Conclusion

We would like your help in making more people aware of our existence so we can engage with them over the effective delivery and development of services and provide them with *Help with health costs*. Further information will be sent out in the Spring.

**W:** [www.ppa.nhs.uk](http://www.ppa.nhs.uk)

The website is the access point for all our Patient Services.

**T:** 0845 850 1166

# Prescription Charges Increase

# 1 April 2004

Regulations have been laid to increase the charges for NHS prescriptions in England from £6.30 to £6.40 per item from 1 April 2004. At the same time, the price of Prescription Pre-payment Certificates - PPCs - (and charges for wigs and fabric supports) will increase.

The new prescription charge applies to all dispensing which takes place on or after 1 April 2004.

For those pharmacies registered to sell PPCs the price will increase to £33.40 for a 4 month PPC and £91.80 for a 12 month PPC. These charges apply for all applications received on or after 1 April 2004 regardless of when the PPC is to start. The price increase will be applied by us to telephone and web-sales on the same basis.

The Department of Health's Leaflet HC12 sets out the new charges and is available on their website at [www.dh.gov.uk/mpi](http://www.dh.gov.uk/mpi).

The HC11 leaflet provides information for patients about the charging arrangements. It is also on the Department's website at the same address.

Patients can contact the Advice Line: 0845 850 1166 (local rate) if they have queries about the charging arrangements.

# What is the NHS dictionary of medicines and devices (dm+d)?

## A single reference source and standard for healthcare systems

Since January 2003 the UKCPRS programme has been run as a joint programme by the Prescription Pricing Authority (PPA) and the NHS Information Authority (NHSIA).

The NHS **dictionary of medicines and devices (dm+d)** is the new name for the single primary and secondary care product of the United Kingdom Clinical Reference Source (UKCPRS) Programme. The dictionary was approved by the Information Standards Board in March 2003 as a Fundamental Standard throughout the health service. The intention is to seek ISB approval for dm+d as an NHS Operational Standard.

Earlier in 2003, the PPA and NHSIA released the Primary Care Drug Dictionary to suppliers and other interested parties via the PPA website. This was a major step towards the concept of a single reference source and standard for healthcare systems. Work is underway to harmonise the secondary care elements into the model for data suppliers from spring 2004. Thereafter medical devices not listed in the Drug Tariff will be incorporated.

The dm+d is a dictionary containing unique identifiers and associated textual descriptions for medicines and devices. It has been developed for use throughout the NHS (in hospitals, primary care and the community) as a means of uniquely identifying the specific medicines or devices used in the diagnosis or treatment of patients. The dictionary provides a link to SNOMED terminology used in clinical systems.

The dm+d is the NHS standard reference for medicines and devices terminology and the basis of the UKCPRS standards requirement of the National Programme for Information Technology (NPfIT). As a single source of reference it will enable clinical system interoperability between diverse clinical systems by ensuring safe and reliable exchange of information on medicines and devices and supporting effective decision support through linkage of data.

## Short Term Benefits of dm+d

### Modernising the prescription payment systems

The PPA developed the first part of the dictionary, comprising the Primary Care elements of the dictionary, and released the first version in January 2003. As well as maintaining and distributing the dm+d, the PPA plans to adopt the dm+d in our new prescription pricing systems which will support electronic payments and electronic transfer of prescriptions (ETP) in the future.

## Long Term Benefits of dm+d

### Patient safety

Improving patient safety is at the heart of all of the NHS IT initiatives being driven forward by Government. It is estimated that medication errors cost the NHS about £500 million per year in additional days spent in hospital. It is intended that the dm+d will:

- Support the seamless transfer of information about the medicines and devices used in the care of patients between primary care practitioners and hospital clinicians - thus reducing transcription errors.
- Enable clinicians to prescribe or dispense the medicines and devices required for patients more safely.
- Enable the reduction of medication errors through the introduction of 'closed loop' prescribing, supply and administration processes.
- Enable all systems (e.g. GP systems, hospital systems) to adopt and use a "common language" to describe medicines and devices and so allow unambiguous transfer of this data between these systems.

## Having Confidence in dm+d

### A single source of reference

One of the key assumptions underpinning the development of the dictionary is that the whole of the NHS and its partners will use dm+d as the national standard for referencing medicines, appliances and devices identification and will use the coding and associated textual descriptions to underpin their business purposes.

This means that the coverage of the dm+d will be comprehensive to meet this wide span of user needs. The current version of the dictionary (Data Model V2) comprises 99.5% by volume of the items prescribed in Primary Care.

## The Future

Plans are in place for secondary care medicines to be added and for additional medicines such as homeopathic products, parallel imports and low volume prescribed products to be added in the same timescale.

# PACT Centre Pages

The PACT Centre Pages report on Cardiovascular prescribing, issued to general practitioners in May 2003, is reproduced here for readers with an interest in patterns and trends of prescribing.

Cardiovascular disease is the main cause of death in the UK (over 240,000 deaths in 2001). Half of all cardiovascular disease deaths are attributed to coronary heart disease (CHD), and CHD is the most common cause of premature death. About a quarter of cardiovascular disease deaths are due to stroke. In general practice more is spent on cardiovascular drugs than any other therapeutic group. Over the last 5 years cost has more than doubled to £472 million per quarter. The number of items has risen by about 70% in this period to nearly 43 million per quarter. The largest increases have occurred in prescribing of lipid regulating drugs, drugs affecting the renin-angiotensin system and antiplatelet drugs (charts 1 and 2).

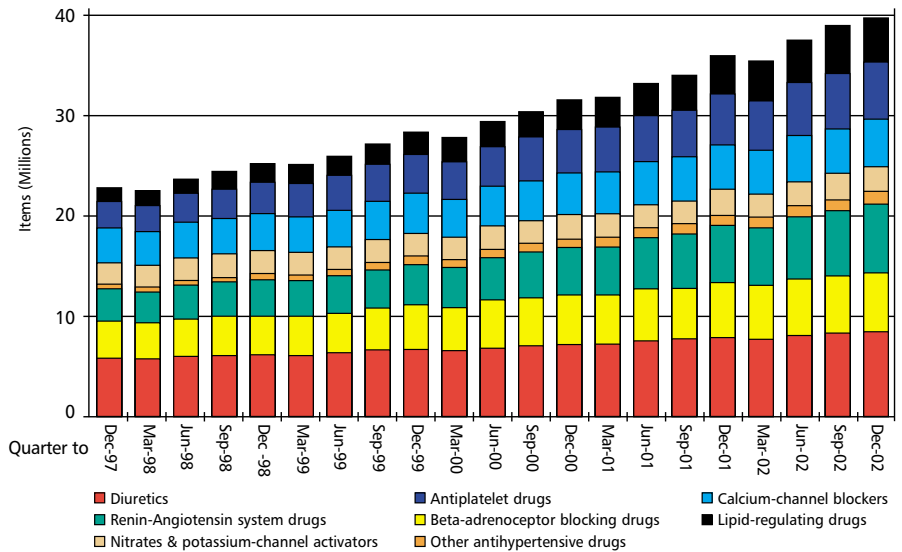
The National Service Framework for Coronary Heart Disease (NSF) provides standards for preventing CHD in high risk patients in primary care. These aim to identify (a) people with established cardiovascular disease and (b) people at significant risk of cardiovascular disease but who have not yet developed symptoms, particularly those with a CHD risk greater than 30% over 10 years. To comply with the NSF milestones, every practice should have a CHD risk register; protocols for systematic assessment, treatment and follow-up; and clinical audit data no more than 12 months old that show whether people at high risk have received the interventions set out in the NSF. Chapter 11 of the NSF tackles management of heart failure, the majority of cases of which are due to CHD. The burden of heart failure on secondary care can be reduced when patients with or at risk of CHD receive appropriate treatment.

## Hypertension

Antihypertensive drug treatment should be initiated in people with sustained systolic pressure greater than 160mmHg or sustained diastolic pressure above 100mmHg. People with blood pressures between 140-159/90-99mmHg should be assessed in relation to the presence or absence of target organ damage, cardiovascular disease, diabetes and a 10 year CHD risk above 15% before deciding whether to treat. Blood pressure below 140/85 mmHg should be the target in patients without diabetes.<sup>2</sup> Recent trials provide direct comparisons of the effectiveness of the main groups of antihypertensive drugs. ALLHAT<sup>3</sup> included 33,357 patients who were identified as having hypertension and one or more risk factors for CHD events. Three drugs were compared: an ACE inhibitor, a calcium channel blocker and a thiazide diuretic. There was no significant difference between any of the drugs for the primary outcomes of fatal CHD and non-fatal MI. ALLHAT provides evidence to support using a thiazide as first choice therapy in most patients; this is in line with the British Hypertension Society guidelines<sup>2</sup> and SIGN guidelines.<sup>4</sup> In another recent trial of ACE inhibitors and diuretics for hypertension in the elderly, it was observed that blood pressure control was similar with either, however, treatment with an ACE inhibitor produced better cardiovascular outcomes in male subjects, particularly non-fatal cardiovascular events and MI.<sup>5</sup> An increased risk of fatal stroke was seen in the ACE inhibitor group.

Choice of initial therapy should be based on pre-existing conditions, contraindications and cost-effectiveness. When blood pressure is uncontrolled by one drug there are two options; add-on therapy, or change to a different drug class. In ALLHAT 40% of patients needed more than one antihypertensive drug to reach the target blood pressure.<sup>3</sup> Which drug to add next will depend on the initial choice of therapy; the Birmingham system provides a method for selecting add-on therapy.<sup>4</sup> Insufficient evidence is available to recommend angiotensin II receptor antagonists (AIIAs) as first line therapy in hypertension. They may be considered as an alternative to ACE inhibitors if cough is a limiting adverse effect<sup>4</sup> or if people with microalbuminuria or proteinuria have a contraindication to ACE inhibitors.<sup>6</sup>

Trends in Prescribing of Cardiovascular Drugs in General Practice in England (Chart 1)



## Hyperlipidaemia

One area of current uncertainty is whether all patients at high risk of CHD would benefit from a statin regardless of pre-treatment cholesterol concentration. The Heart Protection Study<sup>7</sup> has provided some evidence for this. It compared 40mg simvastatin daily to placebo in a wide range of patients (including women, elderly people and people with diabetes) considered to be at high 5 year risk of death from CHD. Deaths from all causes (MNT 56) and major vascular events (NNT 19) were both significantly decreased with simvastatin. The benefit experienced by individuals depended on their overall risk and not just initial lipid concentrations.

Patients at lower CHD risk could benefit from statin therapy, but there are concerns about the cost of this approach and whether in routine practice cholesterol concentrations would be reduced sufficiently to decrease mortality. ALLHAT included a lipid lowering arm comparing the use of pravastatin to usual care in hypertensive patients with moderately raised cholesterol.<sup>8</sup> Unlike other statin trials there were no significant reductions in mortality, CHD events or stroke with pravastatin. This may be because only modest differences in cholesterol concentrations were achieved between pravastatin and usual care. In the PROSPER trial pravastatin reduced deaths from CHD and non-fatal MIs in elderly people at high risk of developing cardiovascular disease or stroke, however stroke risk was unaffected.<sup>9</sup> A recent meta-analysis found that lipid lowering treatment significantly reduces the relative risk of stroke in patients with CHD, particularly when total cholesterol concentration is lowered to under 6.0mmol/l.<sup>10</sup> The NSF1 advises that serum cholesterol concentrations should be lowered to less than 5mmol/l (LDL cholesterol 3mmol/l) or by 30% (whichever is greater) using dietary advice and treatment with statins. Recent trial evidence suggests this advice may need to be reviewed.

## Diabetes

The NICE guidelines for assessment and management of cardiovascular disease risk for people with Type 2 diabetes<sup>6</sup> recommend starting antihypertensive therapy in patients with sustained blood pressures above 140/80 mmHg and either a history of cardiovascular disease or a 10 year coronary event risk over 15% or microalbuminuria/proteinuria. If none of these factors are present then drug therapy is recommended if blood pressure exceeds 160/100mmHg. A target blood pressure of 140/80 mmHg should be the aim unless microalbuminuria is present when a lower target of 135/75mmHg is advocated. ACE inhibitors are the first choice for people with microalbuminuria or proteinuria. AIIAs, beta blockers and thiazide diuretics are first line

treatments in people without albuminuria alongside ACE inhibitors. Statins are recommended for patients with Type 2 diabetes and either total cholesterol greater than 5mmol/l or triglycerides above 2.3mmol/l if they have either a history of cardiovascular disease or a 10 year coronary event risk greater than 15%.

## Antiplatelet drugs

Low dose aspirin is recommended for patients with diagnosed CHD or other occlusive arterial disease.<sup>1</sup> There is insufficient evidence to conclude whether patients with cardiovascular disease other than CHD would benefit from regular treatment with aspirin. Clopidogrel may have a role in the treatment of acute coronary syndrome in selected patients at higher risk of MI or death.<sup>11</sup> For every 100 such patients adding clopidogrel to aspirin for 9 months prevents an additional 2 events of cardiovascular death, non-fatal MI or stroke, but causes major bleeding in 1 patient. If aspirin cannot be tolerated, clopidogrel is a useful alternative but it would not be cost-effective to prescribe it for all patients instead of aspirin.

## Prescribing Data

Prescribing of the main classes of antihypertensive drug has increased over the last 5 years (table 1). Each of these classes has additional indications, therefore it is not possible to tell which class is most frequently prescribed for hypertension. Although spending on thiazide diuretics has risen four-fold over the last 5 years, less is spent on this class than on any other. The highest costs are for calcium channel blockers and ACE inhibitors. Spending on ACE inhibitors has grown at a slower rate than prescribing, which is partly due to enalapril being available off-patent.

In the quarter to December 2002, there were 8.3 million items for diuretics at a cost of £15.9 million (excluding diuretics in combination with other non-diuretic antihypertensive drugs). Bendrofluzide is the most commonly prescribed diuretic, accounting for 93% of thiazide items (3.9 million) and 75% of cost (£4.5 million). Frusemide is the most commonly prescribed loop diuretic, 2.4 million items (89%) and £3.1 million (74%). Spironolactone prescribing has grown by 273% over the last 5 years to 0.3 million items (£1.3 million), presumably due to prescribing for heart failure. Use of potassium sparing diuretics in combination with other diuretics is falling (down 41% to under 1 million items, £4.0 million).

Atenolol is the most commonly prescribed beta blocker (3.9 million items, quarter to December 2002). However more is spent on bisoprolol than atenolol (£5.9 million and £5.7 million respectively). There are 0.5 million items per quarter for bisoprolol. Ramipril and lisinopril are being prescribed almost equally (1.6 million per quarter each) but slightly

Trends in Spending on Cardiovascular Drugs in General Practice in England (Chart 2)

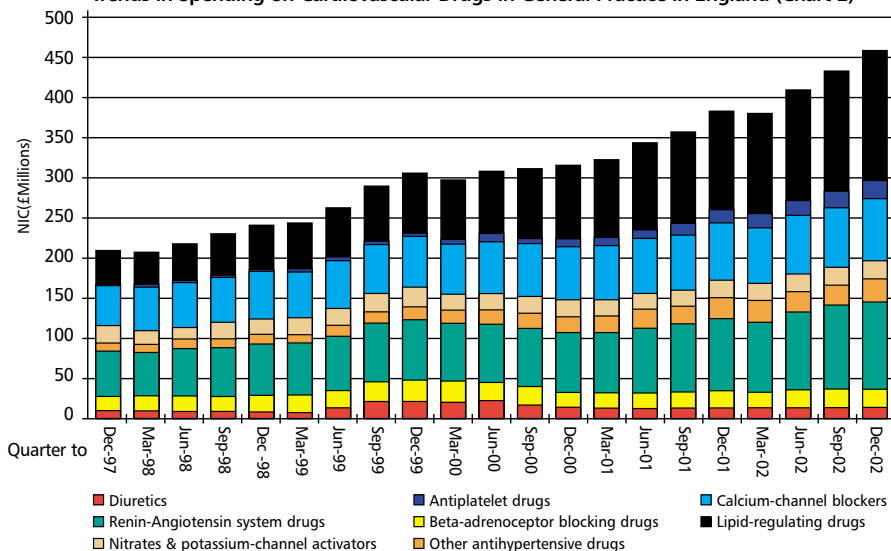


Table 1. Change in prescribing of the main antihypertensive drug classes in the last 5 years

	Items (millions)			Net ingredient Cost (£millions)		
	Quarter to Dec-97	Dec-02	% change	Quarter to Dec-97	Dec-02	% change
Thiazides And Related Diuretics	2.16	4.22	95%	1.35	5.96	341%
Beta-Adrenoceptor Blocking Drugs	3.77	5.87	56%	19.68	23.24	18%
Angiotensin-Converting Enzyme Inhibitors	2.94	5.28	79%	51	73.18	44%
Angiotensin-II Receptor Antagonists	0.16	1.43	768%	4.54	36.92	713%
Calcium-Channel Blockers	3.44	4.66	35%	55.38	75.41	36%
Other Antihypertensives	0.48	1.24	160%	8.86	27.83	214%

more is spent on ramipril (£24.8 million compared to £22.8 million respectively). Although ramipril appears to offer a price advantage over lisinopril when compared using the defined daily dose, the average daily quantity in England is 5mg and ramipril 5mg is more expensive than lisinopril 10mg. Losartan is the most frequently prescribed AIIA (0.5 million items, £14.9 million per quarter). 38% of items for calcium-channel blockers are for amlodipine (1.8 million, £36.6 million) and 23% for nifedipine (1.1 million items, £14.5 million).

In the last 5 years prescribing of antiplatelet drugs has doubled to 5.8 million items per quarter whilst cost is now 11 times higher at £23.3 million per quarter. Aspirin is still by far the most frequently prescribed (5.1 million items, quarter to December 2002) followed by clopidogrel (0.4 million items). Due to the large price difference between aspirin and clopidogrel, 67% of antiplatelet drugs cost is for clopidogrel (£15.7 million) and only 19% for aspirin (£4.5 million).

Use of nitrates remains static, 2.1 million items (£18 million) quarter to December 2002. Nicorandil prescribing is increasing (0.4 million items, £4.3 million). Prescribing of and spending on lipid regulating drugs have both increased around four-fold over the last 5 years (4.9 million items, £161.1 million per quarter). 95% of items for lipid regulating drugs are for statins: simvastatin and atorvastatin are most often prescribed (2.0 million and 1.8 million items per quarter respectively). More is spent on simvastatin (£72.6 million per quarter) than atorvastatin (£58.0 million per quarter).

The total cost of prescribing cardiovascular drugs (NIC/cardiovascular STAR-PU) varies across PCTs (interquartile range 0.57 to 0.70). PCTs in the North (except for North and East Yorkshire, North Lincolnshire and Trent) and in Birmingham and the Black Country spend more on cardiovascular drugs than other PCTs.

References

- 1 National Service Framework for coronary heart disease. www.dh.gov.uk
- 2 British Hypertension Society guidelines for hypertension management 1999: summary BMJ 1999; 319: 630-635
- 3 The ALLHAT Officers & Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic. JAMA 2003; 288: 2981-2997
- 4 Scottish Intercollegiate Guidelines Network. Hypertension in older people. 2001
- 5 The Second Australian Blood Pressure Study Group. A comparison of outcomes with angiotensin-converting enzyme inhibitors and diuretics for hypertension in the elderly. N Engl J Med 2003; 348: 583-592
- 6 NICE. National Clinical Guidelines for Type 2 Diabetes. Blood pressure management
- 7 Heart Protection Study Collaborative Group. MRC/BHF Heart protection study of cholesterol lowering with simvastatin in 20,536 high-risk individuals: a randomised placebo-controlled trial. Lancet 2002; 360: 7-22
- 8 The ALLHAT Officers & Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in moderately hypercholesterolemic, hypertensive patients randomized to pravastatin vs usual care. JAMA 2002; 288: 2998-3007
- 9 PROSPER Study Group. Pravastatin in elderly individuals at risk of vascular disease (PROSPER): a randomised controlled trial. Lancet 2002; 360: 1623-1630
- 10 Differential effects of lipid-lowering therapies on stroke prevention. A meta-analysis of randomized trials. Arch Intern Med 2003; 163: 669-676
- 11 Clopidogrel and acute coronary syndrome. Drug and Therapeutics Bulletin. June 2002; 40: 41-42

Summary

Identifying and treating those people with established CHD and those at significant risk of developing CHD as set out in the NSF is the first priority.

The main groups of drugs for hypertension are similar in efficacy and thiazide diuretics are the most cost effective as first choice therapy.

Many patients require more than one antihypertensive drug to reach their target blood pressure.

For cholesterol management the majority of patients will require drug treatment, benefit from statin treatment depends on overall risk and not just lipid concentration alone.

Aspirin is useful in established CHD, there is insufficient evidence available to support prescribing an antiplatelet drug for patients at low risk of CHD.

The NSF can be found on the following website - [www.dh.gov.uk](http://www.dh.gov.uk)

Our Centre Pages article can also be found on - [www.ppa.nhs.uk](http://www.ppa.nhs.uk)

# Come and talk to the PPA

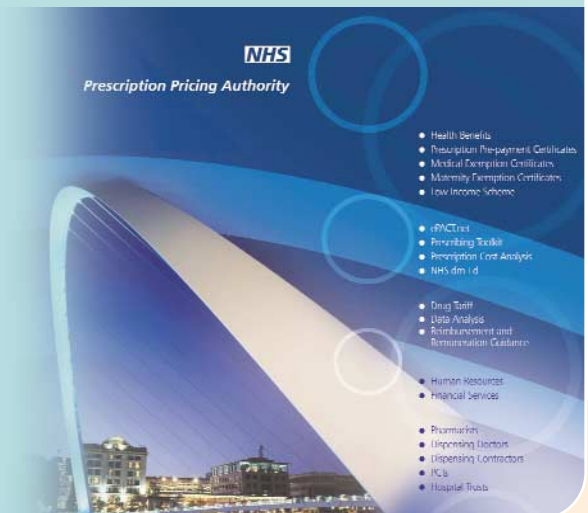
Over the next few months the PPA will have a presence at a number of exhibitions around the country and we hope we will see some of you there.

Our event schedule begins in March with Health Care Computing 2004 (HC2004) taking place at the Harrogate International Exhibition Centre from the 22 - 24 of March.

Visitors to our stand at HC2004 will have the opportunity to learn more about the information products and services that the PPA provides.

In addition a team from the PPA will be on hand to answer questions about the authority and its activities within the wider NHS. This year the PPA will be hosting an invitation based evening event at the Majestic Hotel, Harrogate entitled *Information for You*. The event will take place from 6-7.30pm and will include a prize draw. To receive your invitation come and visit the PPA stand on 22 March.

**WE LOOK FORWARD TO WELCOMING YOU TO OUR EVENTS THROUGHOUT THE YEAR.**



## Future Events

# Stakeholder Forums

Following on from the re-launch of our Health Benefits division as Patient Services on 19 April; we will be running a series of Stakeholder events aimed at our Patient/Public Stakeholders, those working as PALS representatives or at PCT level.

It is our aim to educate frontline NHS staff and the public about Help with Health Costs.

The events are set to take place at the PPA's Manchester division on 19 April and then at the Hotel Pelirocco, Brighton on 22 April.

Further events have been arranged and will take place throughout the year.

Event details will be available on the PPA website [www.ppa.nhs.uk](http://www.ppa.nhs.uk) from the end of March.

If you would like to attend or require further information please contact

**[kirsty.ocallaghan@ppa.nhs.uk](mailto:kirsty.ocallaghan@ppa.nhs.uk)**

Or call **0191 203 5851**



# Feedback

## imPACT

**As we move towards the end of the financial year we would appreciate it if you could take the time to provide us with your opinions on imPACT by completing the questionnaire below.**

**As our key stakeholders we value your opinion.**

● **Do you think that imPACT has improved throughout the year?**

Yes  No  Don't Know

Comments: \_\_\_\_\_

● **In terms of content, are there any areas of particular interest that you would like to see more of?**

\_\_\_\_\_  
\_\_\_\_\_

● **How often do you think imPACT should be produced?**

Monthly  Bi-monthly  Quarterly  Annually

● **How would you like to receive imPACT?**

Paper Format  Electronic Format

● **What would encourage you to contribute to imPACT?**

Comments: \_\_\_\_\_

● **Additional Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for taking the time to complete this questionnaire.**

**Please return to:** Kirsty O'Callaghan, Communications and Media Manager, Planning & Corporate Affairs, 7th Floor, Bridge House, 152 Pligrim Street, Newcastle upon Tyne NE1 6SN.

# Hints and Tips

## Zinc Paste Bandages

**A reminder** - It should be noted that the following products have been deleted from Part IXA of the Drug Tariff within the February edition because they are now licensed as "P" (pharmacy only) products: **Steripaste, Zincaband, Icthaband, Quinaband, Calaband.**

The important point to note is that these products will continue to be reimbursable on Form FP10 if prescribed by doctors or by extended formulary nurses after 1st February but as drugs rather than as appliances. However, if a "plain" Zinc Paste bandage is prescribed by a district nurse or health visitor you will only be able to supply the Viscopaste brand, this being the only Zinc Paste BP bandage still registered as a device and thus prescribable by those nurses.

## "CE" Marked Devices

**Please note** - Further to the last two issues of impACT, we continue to receive queries in relation to Irrigation Solutions and whether or not various products are reimbursable. In your March Drug Tariff you will see that there has now been added a larger size Saline (Fresenius Sodium Chloride 1000ml) and a new "Sterile Water" category which also includes larger size bottles. Again, you are reminded that other brands of Irrigation Fluids are also, in the main, CE-marked devices and therefore should not be supplied against prescription.

## Supplementary Prescribing

**For information** - We regularly receive queries from contractors asking whether or not a supplementary prescriber can prescribe a particular item. In a nutshell, supplementary prescribing is a three-way prescribing partnership between the independent prescriber (generally the medical practitioner), the supplementary prescriber and the patient. Supplementary prescribers are subsequently able to prescribe:

- All General Sales List (GSL) medicines, Pharmacy (P) medicines, appliances and devices included in Drug Tariff Part IX, foods and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All Prescription Only Medicines with the current exception of Controlled Drugs. (NB Subject to Parliamentary approval to changes to the Home Office's Misuse of Drugs Regulations and to related amendments to NHS Regulations, supplementary prescribers will be able to prescribe controlled drugs under the supplementary prescribing arrangement from Spring 2004).

## Anti-embolism Hosiery

**A reminder** - Anti-embolism hosiery is not currently included in the elastic hosiery section of Drug Tariff Part IX therefore orders for such hosiery cannot be reimbursed.

## Extended Formulary Nurse Prescribing

**Please note** - We have received a number of queries from pharmacists asking whether they can dispense an order for Ensure Plus if written on an "NPEF form". However, whilst supplementary prescribing nurses can prescribe borderline substances as listed in Drug Tariff Part XV, extended formulary nurses currently cannot.

## "Non-Part VIII Generics"

**Help us to help you** - As you know, if a prescription is written for a generic drug which isn't included in Part VIII of the Drug Tariff and which is available from more than one source there may be times when we need extra information by way of an endorsement in order that we can reimburse you correctly. If you have supplied a branded item against the order, you might find it easier to endorse the actual brand name, rather than the name of the manufacturer or supplier.

## Premises Retention Fees

**Please note** - For those pharmacy contractors who, in March 2004, don't receive either "Payment for Additional Professional Services" or payment under the "Essential Small Pharmacies Scheme (ESPS)", the Department of Health has agreed a "one-off" payment of £19 for that month only. This payment, if made, will show on your March prescriptions payment schedule, paid 1 June 2004, under the heading "Other Adjustments".

### To summarise:

- Many of the Zinc Paste bandages and variants are now licensed medicinal products, although Zinc Paste BP bandage continues to be a registered device.
- Take care when dispensing irrigation solutions - the majority of these are now classed as CE-marked devices.
- Supplementary prescribers may prescribe most products that a doctor can prescribe, the main exclusions being controlled drugs and the majority of unlicensed medicines.
- Extended Formulary nurse prescribers can't prescribe any unlicensed products including borderline substances.
- Endorse the brand name rather than the supplier if you receive a prescription for a "non-Part VIII generic" which is available from more than one source.
- Anti-embolism hosiery isn't currently allowed on NHS prescription.
- If you're eligible for the "one-off" Premises Retention Fee payment of £19, you'll find it on your June Schedule under "Other Adjustments".