

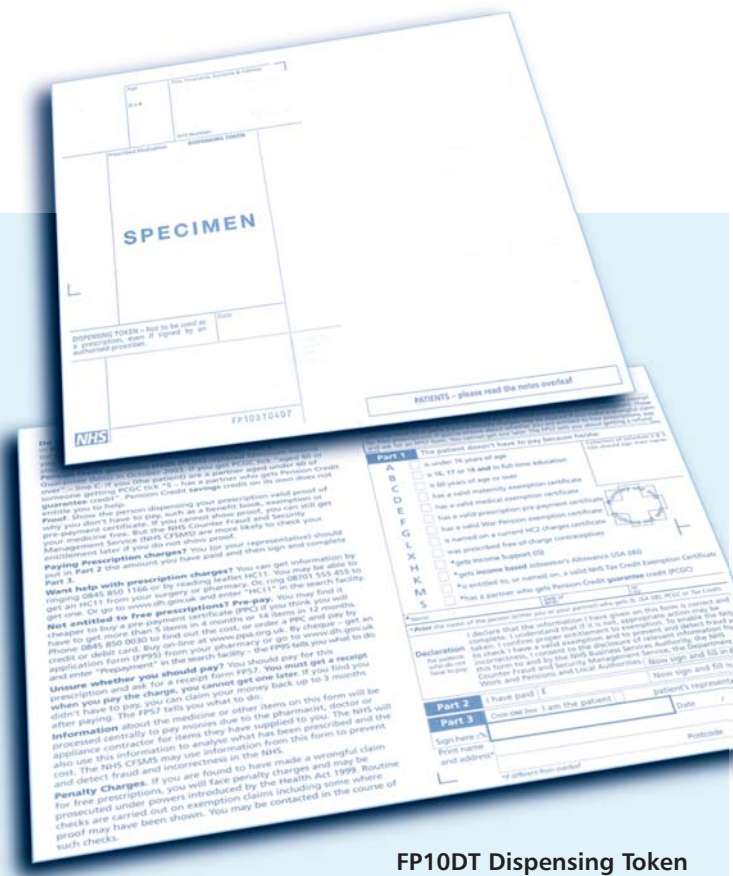
NHS Business Services Authority is ready for the Electronic Prescription Service... are you?

The Electronic Prescription Service (EPS) is part of NHS Connecting for Health's Electronic Transmission of Prescriptions (ETP) programme, which will also include, in the longer term, the integration of the Electronic Prescription Service with the NHS Care Records Service. It is part of the move towards prescribing and dispensing via electronic messages rather than using paper prescriptions.

The NHS Business Services Authority (NHSBSA) is now ready to receive your electronic messages for reimbursement. Although we can process these through our existing systems, we've adapted our systems to make this process and the reimbursement process in general more efficient. You can find out more about that on page 3.

Release 2 of EPS includes the facility for prescribers to electronically sign messages. This means that messages will become valid "prescriptions" that can be dispensed by pharmacies and processed by us. Contractors should note that a new paper form, the FP10DT Dispensing Token, has been designed to capture patient exemption declarations where required. We are asking all contractors to sort these tokens separately within their batches before submitting them to the PPD.

Initially, only five PCTs (Berkshire East, Leicestershire County and Rutland, Liverpool, Southwark and Sunderland) have been selected to be involved in release 2 of EPS in October this year. Further PCTs are expected to go live once the results from these initial five PCTs are known. But this won't be before January 2008.



FP10DT Dispensing Token

Any dispensing contractors operating release 2 compliant systems can dispense electronic prescriptions regardless of whether they are in selected PCTs or not.

Further information on the electronic prescription service can be found on the Department of Health's website <http://www.dh.gov.uk/en/Policyandguidance/Medicinespharmacyandindustry/Prescriptions/ElectronicPrescriptionService/index.htm> and NHS Connecting for Health's website www.connectingforhealth.nhs.uk/systemsandservices/eps

Originals of private prescriptions

The Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980 have been amended to remove the requirement for dispensing contractors to retain dispensed private controlled drug prescriptions for two years. From the 1st of September 2007 dispensing contractors should submit original private controlled drug prescriptions for schedule 2 or 3 CDs to the NHS Business Services Authority using their private controlled drug account and not their NHS prescription account.

The standard form FP10PCD should only be used when prescribing a schedule 2 or 3 controlled drug, although other drugs prescribed at the same time can be included on the form; it is not appropriate for prescribers to use the FP10PCD for all private prescribing.

If contractors need to have a private account set up they should contact their local PCT.



Further action on the recommendations from the Government's Response to the Shipman inquiry

The Misuse of Drugs Regulations 2001 have been amended to incorporate the following changes from September 2007:

- accountable officers now have the authority to appoint authorised witnesses to observe the destruction of controlled drugs
- Operating Department Practitioners are authorised to possess and supply any controlled drug for the purposes of administration to a patient.

These amendments also put the legal framework in place ready for January 2008 for the implementation of new requirements for suppliers of controlled drugs (excluding wholesalers and hospitals) to provide information to the NHS Business Services Authority (NHSBSA). The NHSBSA is running a project with the Department of Health to manage the changes to ordering schedule 1, 2 and 3 CDs using requisitions.

There will be a new dedicated requisition form and the submission document (FP34PCD) for the Private Controlled Drug Account will be amended. The Department of Health will be issuing guidance to

stakeholders, and the NHSBSA will also contact PCTs, pharmacy contractors and prescribers in November to provide more information e.g. how to obtain requisitions and how to submit them to the NHSBSA.

Other changes, which have been laid in this amendment but do not come into effect until February 2008, include the reclassification of midazolam from a schedule 4 to a schedule 3 controlled drug and more flexible arrangements regarding the layout of controlled drugs registers.

A pilot scheme to record the administration by injection of schedule 2 controlled drugs is underway. The intention is to produce a complete audit trail for the supply and use of injectable schedule 2 CDs. Record cards which are distributed by pharmacies with the medication are completed each time a schedule 2 CD is administered to a patient by injection, when cards are complete they are returned to the PCT for checking. The data from the cards can then be compared to the prescribing data available from the NHSBSA. This scheme has now been extended from the original three PCTs to include five more.

New processing technology 'goes live'

We announced in the February edition of impact that we would be starting to process prescription payments through our new processing systems from spring this year.

This programme of introducing the new systems is known as the 'Capacity Improvement Programme' (CIP). It has been designed to modernise the way in which prescription data is captured and so improve the service we are able to offer to all our stakeholders. When it's fully implemented, in conjunction with the Electronic Prescription Service, the reduced cost in processing prescriptions will save the NHS up to £15 million pounds a year.

The new system we are bringing in through CIP uses high-speed scanning equipment and intelligent character recognition software to automate the capture of printed information from prescription forms. This along with information received through EPS is linked to a sophisticated 'rules engine' which works out the value of the prescription based on the quantity, strength, presentation and so-on of what's been dispensed. Over time, because EPS messages feed directly into the CIP rules engine, we should see less need for scanning and keying in by staff.

We are bringing in CIP gradually over the next 12 – 18 months to make sure that it does not change how and when you receive your payments. We are currently processing a small number of pharmacy accounts through CIP and we have sent letters to those pharmacies.

If you have not received a letter telling you that your account is being processed through CIP, you do not need to do anything different with your submission of prescriptions.

Over the next 12 – 18 months, the PPD will gradually move all pharmacy accounts over to CIP processing. We will write to you before hand to let you know when we are going to start processing your account through CIP.

In the meantime, please continue to sort your FP10 prescriptions as you have always done, and in accordance with the guidance contained on the FP34C.

Guidance for accounts being processed through CIP

For those pharmacies that have received a letter telling them that their dispensed prescriptions are to be processed through CIP, the guidance regarding revised sorting instructions in that letter still applies. Those pharmacies should sort separately:

- any prescriptions where broken bulk is claimed; and
- any calendar pack prescriptions where the quantity ordered differs from the pack size, and the prescribed quantity is supplied.

For any queries regarding CIP and its impact on your pharmacy account please contact our prescription processing helpdesk on 0845 610 1171.

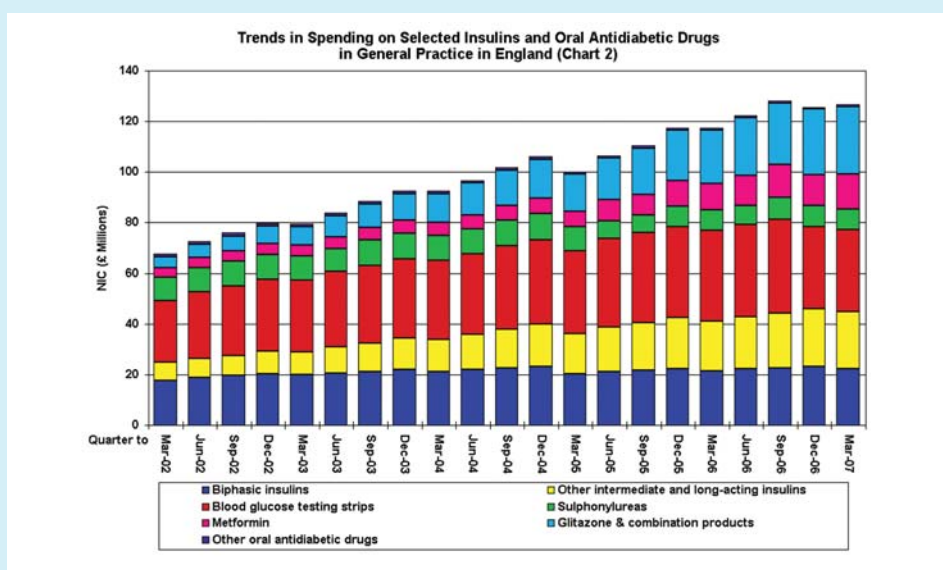
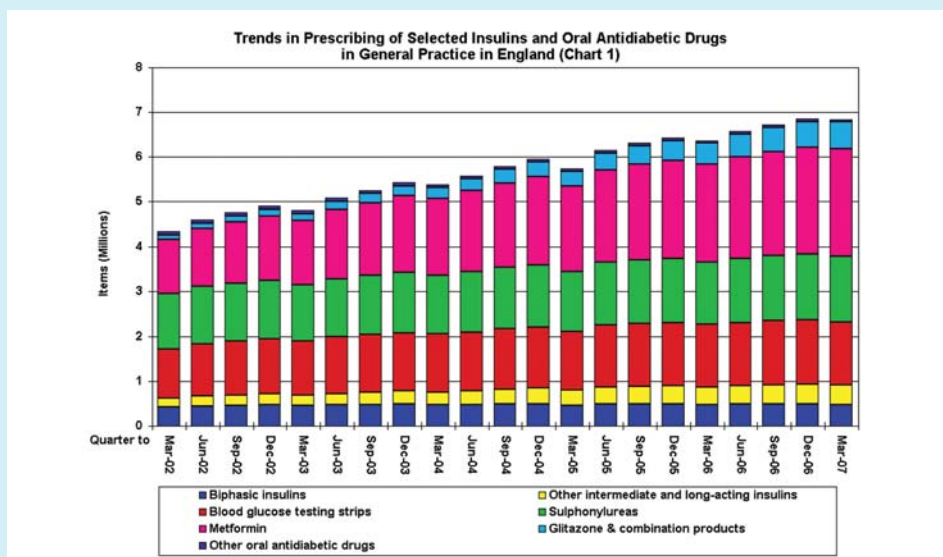
Drugs used in type 2 diabetes

The Prescribing Review report on drugs used in type 2 diabetes, available to general practitioners in August 2007, is reproduced here for readers with an interest in patterns and trends of prescribing.

Out of an estimated 2.35 million people with diabetes in England in 2005 (4.67% of the population), 1.77 million were on GP registers. 92% of the total and a larger proportion of the 'missing' 580,000 are estimated to have type 2 diabetes. Charts 1 and 2 reflect the effect of increasing prevalence on prescribing and costs of products used to manage type 2 diabetes. Coronary heart disease is by far the most common, and consequential, complication of type 2 diabetes. Avoiding preventable cardiovascular (CV) morbidity and mortality is the main aim of prevention, detection and treatment activity.

Preventing type 2 diabetes

Several large studies have shown that preventing or delaying onset of type 2 diabetes is possible in those at risk. In overweight people with impaired glucose tolerance or raised fasting plasma glucose, intensive lifestyle intervention aimed at weight loss, healthy eating and physical activity more than halved the progression to diabetes compared with brief information provided annually (NNT for intensive lifestyle support over 3 years = 7, metformin = 14)¹. Although not licensed for preventative use, the potential role of drugs has received attention recently. Conclusions were as follows: the threshold for drug use in otherwise



healthy people must be high; no trial has shown that prevention with drugs improves outcomes important to patients; lifestyle changes are at least equally effective, much safer and cheaper². Recommendations in NICE Clinical Guideline 43 – Obesity are highly relevant, covering both population measures and specific interventions for individuals³.

Initiating treatment and treatment targets

Interventions to reduce the risk of CV complications are largely the same as for people without diabetes⁴ and are based

on overall CV risk, i.e. smoking cessation, blood pressure control, cholesterol reduction, antiplatelet drugs, increased activity, weight loss and dietary modification (including increased fruit, vegetables and oily fish, reduced saturated fat and salt, moderate alcohol intake). Standard risk calculators have limited validity for people with type 2 diabetes⁵ and clinical judgement is required. Risk calculators based on outcome data for people with type 2 diabetes may be more appropriate. For those at high risk (10 year CVD risk > 20%), priority should be given to controlling blood pressure and reducing

Table 1: Patients with type 2 diabetes reaching treatment targets (QOF versus NDA)

Treatment Target	QOF (2004/05)	NDA primary care (2004/05)
BP < 145/85 mmHg (QOF 12)	70.3%	58.6%
Cholesterol < 5 mmol/l (QOF 17)	71.8%	58.1%
HbA1c < 7.5 (QOF 6)	58.8%	42.4%

cholesterol with statins⁶. **Table 1** compares Quality and Outcomes Framework (QOF) figures for patients reaching QOF treatment targets with data collected from primary care sources for the National Diabetes Audit (NDA) for 2004/05. Differences are probably due to the effect of QOF exception reporting. NICE recommends targets for blood pressure of < 140/80 mmHg or < 135/75 mmHg if microalbuminuria or proteinuria is present, and that HbA1c should be between 6.5-7.5%, according to individual vascular risk.

Empowering people with diabetes is a core component of the National Service Framework (NSF) delivery strategy and NICE Technology Assessment 60 recommends that structured patient education, such as DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed), be made available to all people with diabetes at the time of diagnosis and subsequently as required. An important feature of empowerment is reaching agreement on personally meaningful, realistic and achievable targets.

Blood pressure

A difference of 10/5 mmHg between a group randomised to tight blood pressure control (achieved 144/82 mmHg) and a group randomised to less tight control (achieved 154/87 mmHg) resulted in large and significant reductions in diabetes related death, heart failure, stroke and deterioration in visual acuity⁷. Among the more than 13,000 people with diabetes enrolled in ALLHAT, neither amlodipine nor lisinopril was superior to chlortalidone in reducing the rate of end-stage renal disease, myocardial infarction or fatal CHD⁸. Thiazide diuretics are included in current NICE guidance as first line options for people with type 2 diabetes without microalbuminuria or proteinuria. ACE-inhibitors are recommended for people

with microalbuminuria or proteinuria. Angiotensin receptor antagonists should be substituted only when ACE-inhibitors are truly not tolerated, because there are more outcome data for the latter.

Lipids

Statins are recommended where there is evidence of CV disease and for primary prevention when clinical judgement is that 10 year estimated risk is > or equal to 20%. Among the 5,963 people with diabetes (90% with type 2 diabetes) enrolled in the Heart Protection Study a fixed 40mg dose of simvastatin was safe and effective, and reduced major coronary events and strokes by about a quarter⁹. It has not been established that more aggressive lipid lowering therapy is warranted¹⁰. NICE recommends using the statin with the lowest acquisition cost.

Blood glucose

Although observational studies suggest an association between persistent hyperglycaemia and macrovascular complications in type 2 diabetes, evidence that hypoglycaemic agents reduce these is limited. A recent systematic review and meta-analysis¹¹ found that improved glycaemic control translated into reductions in peripheral vascular disease and stroke but concluded that the prevention of cardiac events must be effected by means of antihypertensive, lipid-lowering, and platelet inhibiting measures. Metformin is the only hypoglycaemic agent shown to reduce deaths and prevent both microvascular and macrovascular complications. Unless contraindicated, it is the first line choice for all people whose blood glucose is inadequately controlled with lifestyle interventions. A generic sulphonylurea (e.g. gliclazide) is normally recommended when metformin is contraindicated and for those people who do not tolerate it. Tolerability can be improved by slow titration (over 3-6

weeks)¹². Combining metformin and a sulphonylurea is suitable for those whose blood glucose is inadequately controlled with monotherapy. Modified release and combination preparations are considerably more expensive than alternatives and have not been shown to be more effective, safer or better tolerated. Rosiglitazone and pioglitazone (glitazones) should only be used in combination with either metformin or a sulphonylurea where one or the other is contraindicated or not tolerated¹³. Recent studies, raising the possibility that rosiglitazone may increase the risk of myocardial infarction and CV death¹⁴ and suggesting no effect of pioglitazone on a composite CV outcome, emphasise that effectiveness in reducing blood glucose may not always translate into meaningful benefits for patients. Studies confirming that glitazones increase the risks of heart failure and osteoporotic fracture, and regulatory concern regarding macular oedema, underline this. The role of other newer drugs such as sitagliptin and exenatide has yet to be established.

Insulin therapy is usually considered if maximum tolerated doses of two oral agents combined with maximum achievable lifestyle modification do not adequately control blood glucose. Triple therapy including a glitazone might be considered if insulin is not acceptable, but considerable caution is required. Decisions in primary care will usually be based on specialist advice. 30% of people with type 2 diabetes may require insulin¹⁵. Choice of insulin for type 2 diabetes is based on local experience, patient factors and cost. Continuing metformin may lessen the number of injections required, reduce the dose of insulin needed and minimise weight gain. If metformin is not tolerated, a sulphonylurea should be continued. Night time isophane insulin or twice daily biphasic insulins are typically used for type 2 diabetes. There is little evidence to suggest that glargine or detemir reduce HbA1c compared with isophane insulin in patients with type 2 diabetes or that either reduces severe hypoglycaemia¹⁶. It seems reasonable to consider that NICE guidance not to prescribe insulin glargine for people with type 2 diabetes unless they suffer from recurrent hypoglycaemia, require assistance with insulin or would otherwise need twice daily basal injections with oral antidiabetic drugs also applies to detemir. Biphasic analogue insulins have not been shown to have any consistent advantages over other pre-mixes¹⁷. Inhaled insulin may be suitable for the very small number of people with

Drugs used in type 2 diabetes (Cont.)

type 2 diabetes who, in addition to requiring fast-acting insulin, have proven phobia to injections or persistent injection site problems.

There is a continuing debate about blood glucose self-monitoring by people with type 2 diabetes who do not require insulin. Some observational studies have suggested benefit but results of randomised controlled trials (RCT) have been inconclusive. One large RCT found evidence of harm. No significant improvement in glycaemic control was found in a recent trial comparing HbA1c monitoring by health professionals with either less intensive or more intensive blood glucose self-monitoring for 12 months¹⁸.

Prescribing data

(Reporting quarter = January-March 2007, index quarter = January-March 2002)

The cost of prescribing hypoglycaemic drugs has more than doubled over the last 5 years. There has been little change in the relative proportions of oral antidiabetic drugs and insulins prescribed, but expenditure on oral drugs has increased to a greater extent (see charts 1 and 2).

Metformin prescribing has doubled over the last 5 years, accounting for 54% (2.4

million items) of antidiabetic drug items and 28% of cost (£13.8 million). There has been an 18% increase in prescribing of sulphonylureas to 1.4 million items; cost has fallen by 12% to £8.2 million. Gliclazide accounts for a quarter of all antidiabetic drug prescribing (1.1 million items) and 11% of cost (£5.5 million); it is the most commonly prescribed sulphonylurea. Rosiglitazone prescribing and spending has risen almost three-fold in the last 5 years to 307,000 items and £14.0 million (28% of all spending on oral antidiabetic drugs). Pioglitazone accounts for 132,000 items at a cost of £5.3 million. Prescribing of the combination drug, rosiglitazone with metformin, stands at 153,000 items and accounts for 15% of all spending on oral antidiabetic drugs (£7.3 million). In total the glitazones and the combination of glitazones with metformin represent 54% of all expenditure on antidiabetic drugs but only 13% of items.

Intermediate- and long-acting insulins account for 74% of all insulin prescribing and 73% of cost. Insulin glargine is the most commonly prescribed long-acting insulin: 248,000 items (27%) at £14.2 million (32%). Biphasic insulins account for 478,000 items at £22.4 million. Prescribing of blood glucose testing strips has risen by 30% to 1.4 million items costing £32 million.

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Key Messages

Intensive support for lifestyle modification can prevent or delay progress to type 2 diabetes.

Multifactorial management of cardiovascular risk reduces preventable morbidity and mortality.

Lowering lipids and blood pressure is associated with substantial cardiovascular benefit.

Metformin also reduces macrovascular complications.

Self-monitoring of blood glucose may be of little or no value for the majority of people with type 2 diabetes.

Helping patients to pay for their healthcare

As we move into the winter months with all the traditional ailments that strike, it's important that patients know that help with health costs is available.

There are a number of different ways to get help with health costs. Our services include:

- Administration of the NHS Low Income Scheme
- Selling prescription pre-payment certificates (PPCs)
- Issuing medical exemption certificates
- Issuing maternity exemption certificates
- Issuing NHS tax credit exemption certificates on behalf of the Department of Health

We have the information leaflet HC11, **Help with Health Costs**, along with other available literature for you to display to help patients find out more. Please log onto <http://www.ppa.org.uk/ppa/HC16April07.doc>

We also have a dedicated Help with Health Costs advice line **0845 610 1110**.

Spreading the cost of a pre-payment certificate

Did you know that patients can spread the cost of an annual pre-payment certificate (PPC)?

PPCs can be used for all NHS prescription charges incurred during the period of the certificate, no matter how many. They can lead to real savings for people who need a large number of items.

Patients can pay for an annual PPC over 10 monthly instalments by Direct Debit. Please visit our website www.ppa.org.uk/ppc for more details or phone our dedicated helpline **0845 850 0030**.

Changes to the PPC application form

Due to the changes to the PPC scheme, a new version of the PPC application form, FP95 version 0707, was introduced on 1 July 2007.

If you hold stocks of the FP95 for distribution in your area, **please make sure that you have the latest version**. You can order supplies of the new version as normal from your Primary Care Trust forms supply unit.

Can you be a 'key contact'?

We are always looking to add new people to our list of key contacts of people who are at the forefront of healthcare delivery. With your help and by working in partnership, we can ensure that up to the minute information about our patient services is readily available and can be easily accessed by those who need it.

If you would like to register as a key contact, please get in touch with: Terry Luck, Customer Service Manager, e.mail: terry.luck@ppa.nhs.uk or phone **0191 203 5525**.

We very much look forward to working with you.

Department of Health consultations

A further consultation by the Department of Health was published on 6 September 2007 on the revised proposals for the arrangements under Part IX of the Drug Tariff for the provision of stoma and incontinence appliances – and related services – to primary care. This consultation will close on 29 November 2007.

The Department of Health is also expected to hold a consultation in the autumn concerning prescription charges following an internal review based on recommendations from the Health Select Committee. The consultation will allow the public to contribute their views on any proposals before a final decision on future prescription charges. Responses to a consultation should be sent in within three months of the date of publication.

You can find out more on the department's website

<http://www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm>

Supply of TB drugs to patients – **changes to regulations and advice on implementation**

The NHS (Charges for Drugs and Appliances) Regulations 2000 have been amended from 1 September to allow medicines for the treatment of tuberculosis to be provided free of charge in TB clinics or via a patient group direction.

The Department of Health has not made medicines for the treatment of TB generally exempt from prescription charges. It is available free of charge only in certain circumstances – in a dedicated TB clinic or via a patient group direction where a named regulated healthcare professional is authorised to supply or administer TB medicines. The intention is to encourage people with TB to be seen regularly in TB clinics where they can be properly assessed and their treatment supervised by TB experts.

If an FP10 prescription form is used to prescribe TB medicines, the patient will have to pay prescription

charges unless they are exempt. However, patients with TB should, ideally, always be treated in specialist TB clinics where the medicines can now be supplied free (on the NHS), or could be given TB medicines in the community by a TB nurse specialist or other regulated healthcare professional under a patient group direction.

This change is a public health protection measure. If someone doesn't complete their treatment it increases the risk of development of drug-resistant TB, and also increases the risk that they will infect others. The wider gain here is in protecting other people from contracting TB from infected people who could be cured completely.

More information is on the Department of Health website: <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/index.htm>

Contact details for the NHSBSA

For general enquires relating to the NHSBSA, contact the Head Office:

Bridge House, 152 Pilgrim Street, Newcastle upon Tyne, NE1 6SN

0191 232 5371

For all queries relating to the NHS Low Income Scheme, contact Patient Services:

0845 850 1166

For general queries, prior to applying for Prescription Pre-payment, Medical and Maternity Exemption Certificates:

0845 850 0030

For specific queries, after applying for/receiving Prescription Pre-payment, Medical and Maternity Certificates:

0845 601 8076

For queries about NHS Tax Credit Exemption Certificate:

0845 609 9299

For enquiries relating to Pharmacy Processing, Prescription Searches, Personal Administration, Dispensing Doctors and Contractor Payment Information contact the new Prescription Pricing Help Desk on:

0845 610 1171

This number should be used with immediate effect and replaces any existing numbers you currently use.

For enquiries relating to applications for the European Health Insurance Card (EHIC):

0845 605 0707

0191 203 5555 (from outside UK)

Ehicenquiries@ppa.nhs.uk

Enquiries on all PPA Electronic Systems (EPACT, ePACT.net and Prescribing Toolkit) and on the availability and content of reports produced by the PPA:

0191 203 5050

help@ppa.nhs.uk

www.ppa.nhs.uk

www.nhsbsa.nhs.uk

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