

# Have your say on the future of 'Impact'

NHS Prescription Services is planning on reviewing the way that we keep customers like you up-to-date with news and information, including this newsletter, 'Impact'. We'd like to find out what you think of it to help us shape its future.

**Do you think we send it too often or not enough? Got a view on what goes in it or what format we produce it in?**

**Tell us through our short online questionnaire.**

The questionnaire will be up until Friday 30th April, so you've got a few weeks to tell us.

[www.surveymonkey.com/s/impactreadersurvey](http://www.surveymonkey.com/s/impactreadersurvey)

## Hints&Tips

### ● Clopidogrel hydrogen sulphate 75mg tablets

If a prescription is prescribed as either Clopidogrel 75mg tablets only (with no salt stated), Clopidogrel Besilate 75mg tablets or Clopidogrel Hydrochloride 75mg tablets regardless of any endorsement NHS Prescription Services will reimburse the Part VIII price.

If Clopidogrel hydrogen sulphate is prescribed it will require an endorsement of either the brand and/or manufacturer dispensed to allow NHS Prescription Services to carry out reimbursement on initial submission. If endorsement information is not present for prescribed orders of Clopidogrel hydrogen sulphate 75mg tablets then NHS Prescription Services is required to refer back the item to contractors for clarification, which in turn will delay payment.

## Come to an OPEN DAY and learn something new!

And that's from people who've been to one! Last year, 95% of people who came to one of the monthly open days NHS Prescription Services holds, said that it met their objectives. Top reasons why were because it was very informative about our process and the opportunity to talk to us face to face. And even if you think you couldn't learn anything new by a visit, you'd be surprised. 87% learnt new things about submitting prescriptions, 97% about our processing system, and 88% about our customer service.

So whether you work in a pharmacy, GP's surgery with a dispensary or a PCT log on to our website for dates and venues for each month, for the rest of the year, and how to book on our website:

[www.nhsbsa.nhs.uk/prescriptions/opendays](http://www.nhsbsa.nhs.uk/prescriptions/opendays)

Can't make an open day or would prefer a more tailored approach? Read the article on page 3 about the visits we're making to dispensaries.

## Contact details for the NHS Prescription Services

Got a question about dispensing contractor reimbursement, endorsement guidance, or prescription searches? Contact our helpdesk.

Phone **0845 610 1171** or  
e-mail [prescriptionpricinghelpdesk@ppa.nhs.uk](mailto:prescriptionpricinghelpdesk@ppa.nhs.uk)



[www.nhsbsa.nhs.uk/prescriptions](http://www.nhsbsa.nhs.uk/prescriptions)

Prescription Services



Prescription Services

Prescribing and Dispensing Newsletter

# impact

March/April 2010

## NHS Prescription Services changes how it processes expensive items

### NHS Prescription Services has brought in changes to sorting prescriptions to support accuracy improvement in processing expensive items.

From April dispensed prescriptions (which you will send to us in May for processing) we are asking contractors to change what they sort in to the red separators that we provide. Contractors must now sort separately prescription forms containing individual items with a net ingredient cost (NIC) of £100 or more and 'specials'. This change will allow us to pay particular attention to pricing those items. You no longer need to sort calendar pack items into the red separators.

Prescription forms where a 'broken bulk' claim applies to one or more items on the form will still need to be sorted.

From April 2010 dispensed prescriptions you should use the red separators we provide to sort separately:

- Broken bulk items (as you currently do);
- Items with a NIC of £100 or more; and
- 'Specials'.

Your April submission document has been updated to reflect these changes.

We have sent a letter to all pharmacy contractors to explain the changes and you will find a copy on our website [www.nhsbsa.nhs.uk/prescriptions/submissiondocuments](http://www.nhsbsa.nhs.uk/prescriptions/submissiondocuments)

If you have any questions about these changes please contact our helpdesk for help and advice. 0845 610 1171 or email [prescriptionpricinghelpdesk@ppa.nhs.uk](mailto:prescriptionpricinghelpdesk@ppa.nhs.uk)

### What to sort as a 'special'

Include prescription forms with any of the following items within this sorting category:

- 'Specials' - an unlicensed medicine manufactured in response of a prescription for an individual patient where a licensed product is not available. They may be procured from a third party e.g. specials manufacturer.
- Prescription items endorsed that they have been extemporaneously prepared (see Drug Tariff Part IIIA)
- Prescription items where the prescriber has provided additional product information not in the product information field e.g. preservative-free or sugar-free within the dosage instructions.

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# Changes to using your red separators for sorting

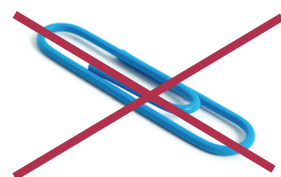
## Hints and tips for preparing your batch

We're sent 33 million prescription forms every month for processing. Before we even start processing them we have to make sure that they're in the right condition to start the process. We like to keep this part of the process as short as possible so that we can spend more time on what matters - calculating your reimbursement and remuneration! So here are a few things that would help.



Here's an example of a well prepared batch sent in to us.

### No thanks!



Paper clips get stuck in our scanner. We have to remove every single one by hand

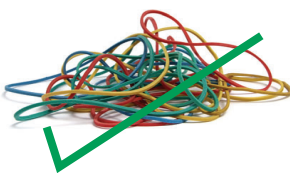


Staples and the marks they leave when they're taken out make prescription forms get stuck in our scanners and slow things down

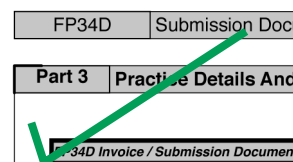


Some people like to separate each doctor's prescriptions by wrapping them with a piece of paper. Save your time and paper - we take them off and throw them away!

### Yes please!



Use these to keep your exempt and paid bundles secure. And less is best! As a guide, band up each whole exempt and paid bundle separately, each red separator bundle and then the whole batch together.



We post out the correct form you should use for every month's submission. Only use the original one we send to you - no copies or copies of old ones or copies from a friend! Our helpdesk can send you a replacement if you need one.

# "Help Us to Help You"

In the September 2009 edition of *Impact* we invited contractors to request a visit from our dedicated Customer Services Team. The purpose of these visits is to facilitate face to face engagement between ourselves and our customers in an environment where we can impart direct advice relating to individual issues, including effectively endorsing prescriptions and sorting and submitting accounts. They also provide an opportunity for us to give an overview of the system we use to process prescriptions. We can often identify how our customers can optimise their efficiency in a variety of areas, such as eliminating prescription switching for example. Since October 2009, armed with a maxim of 'Help us to Help you', we have been busily voyaging throughout England on our mission to inform, to listen, and to provide advice to our customers in order to help them achieve best working practice.

In October 2009 representatives from our team attended a Day Lewis Conference in London which brought us into contact with around 150 Pharmacists. We also had a stand at the Pharmacy Show held at the Birmingham NEC again giving us the opportunity to engage with more than 175 Pharmacists. Although we were able to answer a number of individual enquiries at these events, we were also very pleased to accept a number of invitations from contractors to visit their shops, which we will be doing in the near future.

In December 2009 we held workshops in four dispensing doctors' practices in North Yorkshire, which were attended by representatives from 19 different practices. We visited three pharmacy contractors in Leicester who owned 21 shops between them, and met with three pharmacy contractors in Liverpool who owned four shops collectively. At every visit we encourage each contractor to fill in a Customer visit feedback form which we use to assist us in improving the quality of the visits we provide, and we have been overwhelmed by the positive responses we have received. One contractor informed us shortly after a visit; "What a great idea-should have done it years ago! Very helpful and knowledgeable team. I learned some useful tips".

A noticeable theme emerging from the feedback we have received is that contractors are encouraged by the advice given regarding time saving measures, such as unnecessary endorsements and reducing the amount of referred back items they receive each month. And it isn't just our customers who have found the visits to be a positive experience. Tracy Toye, Customer Services Team member commented; "Visiting our customers and being able to put a face to a name is a rewarding experience. I enjoy listening to contractors and giving them advice about how to maximise their experience of the services we provide. I am delighted that after

acting upon the suggestions I have made to contractors, they have been able to save valuable time, and have also had their personal concerns addressed, such as how to fully understand their Schedule of Payments each month. Every customer I have met has been really friendly and I am looking forward to going on more visits in the future".

In addition to organising visits with contractors who have previously expressed an interest in this service, we are also currently engaging with LPC's and PCT's with the aim of identifying central meeting points nationwide to host future workshops. This will allow us to meet with more customers and maximise both your and our time. From previous experience these workshops have been a resounding success as contractors have had the opportunity to share their ideas and experiences with fellow professionals.

We would like to take this opportunity to send our thanks to every customer who has received a visit from our Customer Services Team, and we look forward to providing this mutually beneficial experience to many more contractors in the near future.

To arrange a contractor visit, please contact us:  
phone 0191 2035867  
or email  
[contractorvisit@ppa.nhs.uk](mailto:contractorvisit@ppa.nhs.uk)



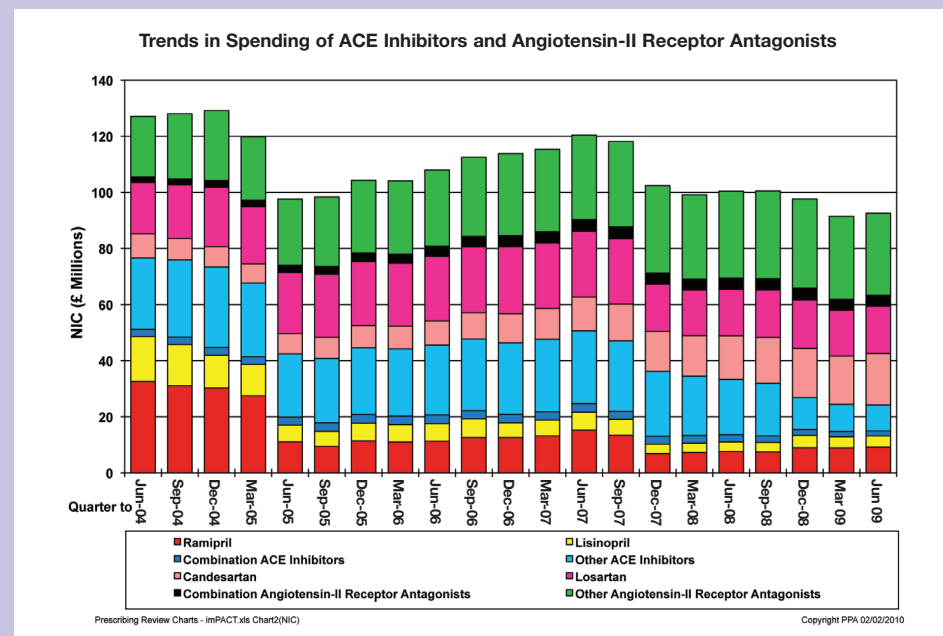
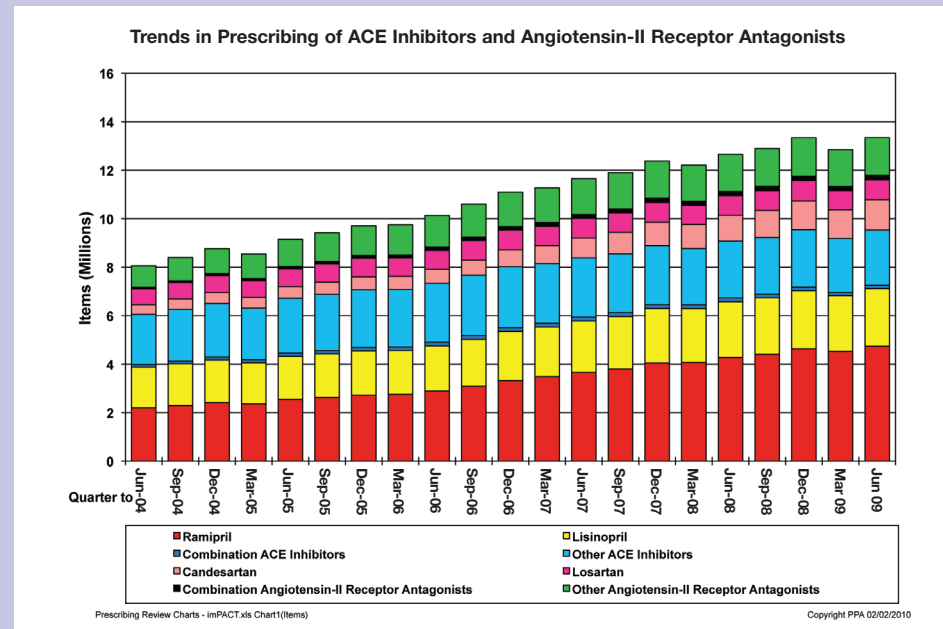
# The Prescribing Review report on ACE inhibitors and angiotensin-II receptor antagonists,

available to general practitioners in November 2009, is reproduced here for readers with an interest in patterns and trends of prescribing.

Angiotensin-converting enzyme (ACE) inhibitors and angiotensin-II receptor antagonists (AIIRAs) both target the renin-angiotensin system. ACE inhibitors inhibit the conversion of angiotensin I to angiotensin II.<sup>1</sup> AIIRAs antagonise the binding of angiotensin II to the AT1 receptor which mediates most of the antihypertensive effects usually associated with angiotensin II. Angiotensin II is important as it has numerous effects, including stimulation of the sympathetic nervous system, vasoconstriction, increasing aldosterone release and sodium retention, which can result in hypertension. Currently there are 11 ACE inhibitors, seven combination ACE inhibitors, seven AIIRAs and six combination AIIRAs available in the UK.<sup>1</sup> Although ACE inhibitors and AIIRAs work at different steps of the renin-angiotensin system<sup>2</sup>, they are broadly indicated for similar conditions and the National Institute for Health and Clinical Excellence (NICE) offers guidance on the use of these drugs in the following areas: Heart Failure<sup>3</sup>, Hypertension<sup>4</sup>, Myocardial Infarction Secondary Prevention<sup>5</sup>, Type 2 Diabetes<sup>6</sup>, and Chronic Kidney Disease.<sup>7</sup>

## Choosing between ACE inhibitors and AIIRAs

NICE recommends that for indications where either an ACE inhibitor or an AIIRA could be prescribed, an ACE



inhibitor is routinely the drug of choice. If either an ACE inhibitor or an AIIRA is prescribed, NICE recommends using a drug that can be taken once a day (if possible), is generically prescribed, and minimises cost.<sup>4</sup>

Both ACE inhibitors and AIIRAs have a good evidence-base to support their use. However, the fact that the ACE inhibitors have been around longer has enabled a more robust evidence base to become

established across all indications. There is a wide range of generic ACE inhibitor products available, unlike for AIIRAs where there are currently none, and this makes ACE inhibitors the more cost-effective option. There is poor evidence to support the use of one ACE inhibitor over another and thus, NICE have tended to focus on recommending their place as a group in cardiovascular disease management. The same applies to AIIRAs.

Table 1: % Prescribing of ACE Inhibitors (excl. combination products) vs AIIRAs (excl. combination products) for the Quarter to June 2009

SHA	% ACE Inhibitors (excl combinations)	% AIIRAs (excl combinations)
South East Coast	68.34%	31.66%
London	69.64%	30.36%
North West	70.82%	29.18%
East of England	72.30%	27.70%
South Central	72.43%	27.57%
West Midlands	72.68%	27.32%
Yorkshire and the Humber	72.78%	27.22%
South West	73.28%	26.72%
East Midlands	73.39%	26.61%
North East	77.15%	22.85%

From Charts 1 and 2, ramipril is the most commonly prescribed ACE inhibitor at 4.7 million items and a cost of £9.2 million for the quarter to June 2009. Ramipril represents 50% of prescribing of ACE inhibitors and 38% of the cost. 96% of the number of items for ramipril represent prescribing of the capsule form. Lisinopril is the second most commonly prescribed ACE inhibitor and accounts for 25% of ACE inhibitor items (2.4 million) and 16% of the cost (£4 million). Of the group of 'other ACE inhibitors', perindopril (both arginine and erbumine salts) is the third most commonly prescribed ACE inhibitor. Perindopril represents only 15% of ACE inhibitor items (1.4 million) but it accounts for £6.2 million (less than a third the number of items and yet two thirds of the cost of ramipril). The Clinical Knowledge Summaries (CKS) service recommends that ACE selection should generally be limited to the use of lisinopril, ramipril or enalapril<sup>8</sup>. Lisinopril, ramipril and enalapril represent three of the most cost-effective ACE inhibitors and between them, they cover the full set of licensed indications that ACE inhibitors as a group cover. Patients' comorbidities will also affect drug selection. NICE has recommended that AIIRAs are an alternative choice to ACE inhibitors when an ACE inhibitor is clinically indicated but not tolerated (due to a persistent troublesome dry cough). Good clinical practice would dictate that ideally an AIIRA should be used for a condition it is licensed for. Currently, candesartan is the most cost-effective AIIRA but the patent on losartan is due

to expire March 2010 and this will enable generic products to become available. From Charts 1 and 2, in the last quarter, 1.3 million candesartan items were prescribed at a cost of £18.3 million. This represents a similar number of items to perindopril at nearly three times the cost.

## Tolerability of ACE inhibitors and AIIRAs

Unlike ACE inhibitors, AIIRAs do not inhibit the breakdown of bradykinin, and are therefore less likely to cause the persistent and troublesome dry cough that people taking ACE inhibitors may experience.<sup>1</sup>

In a Micromedex review, the incidence of cough in patients taking ACE inhibitors has been reported to be up to approximately 12%. Among patients experiencing cough, between 20% and 60% will rate it intolerable and request withdrawal of therapy.<sup>9</sup>

A recent systematic review investigated the use of ACE inhibitors and AIIRAs in people with essential hypertension, and one of the comparisons looked at rates of cough.<sup>10</sup> Rate of cough with ACE inhibitors was 9.9% compared with 3.2% for AIIRAs (absolute risk difference = 6.7%). This data was from RCTs whereas rates of cough with ACE inhibitors have been found to be notably less in observational studies. Cough is common in people with heart failure and other comorbidities but if the cough is persistent and troublesome and if other causes have been ruled out and a renin-angiotensin type drug is indicated then NICE recommends switching to an AIIRA.

## Prescribing practices to consider exploring

When considering Table 1, the distribution of AIIRAs compared with ACE inhibitors appears to represent a higher proportion of AIIRA prescribing than would be expected based on the small percentage of people who are not likely to tolerate an ACE inhibitor. At a PCT level, this variation ranges from AIIRA prescribing representing just over 20% to nearly 40% volume in terms of items. AIIRAs are significantly more costly than ACE inhibitors and NICE recommends that AIIRAs are an alternative choice to ACE inhibitors only when an ACE inhibitor is clinically indicated but not tolerated. Therefore, supporting clinicians to follow NICE guidelines and initiate patients on one of the lower cost drugs can help drive prescribing costs down.

Combined treatment with both an ACE inhibitor and an AIIRA currently has a limited role. For a relatively small proportion of heart failure patients who are symptomatic despite use of diuretic, beta-blocker and ACE inhibitor, options include to either add in spironolactone, or to add in an AIIRA.<sup>11</sup> Both options increase the risk of worsening renal function and hyperkalaemia, thus increased monitoring is essential. Therefore, evidence suggests that only a small proportion of patients with heart failure are eligible for consideration of combined ACE inhibitor and AIIRA use. In all other scenarios, combined treatment with an ACE inhibitor and AIIRA is not routinely recommended and recent publications have found little evidence to support this role.<sup>12,13</sup>

## The Prescribing Review report on ACE inhibitors and angiotensin-II receptor antagonists (cont.)

Use of fixed-dose combination products (e.g. ACE inhibitors or AIIIRAs combined with a diuretic or calcium channel blocker) is another feature which generates relatively high prescribing costs. Despite the widely held view that fixed-dose combinations improve concordance, there are few good quality studies which show this and even fewer which demonstrate improved outcomes.<sup>14</sup> Therefore, in most situations, regimens containing single component drugs should remain the treatment of choice where possible.

### Prescribing Data

(Reporting quarter = April-June 2009, Index quarter = April-June 2004)

Prescription items for ACE inhibitors and AIIIRAs have increased by 66% in the last 5 years to 13.4 million items. Although the overall cost has decreased by 27% to £93million, this cost reduction can be attributed to the fact that ACE inhibitors represent 71% of items but only 26% of the cost of the drugs for these two groups combined.

Prescribing of AIIIRAs has increased by 91% to 3.8 million items, with cost rising by 35% to £68.3 million. In contrast prescribing of ACE inhibitors has increased by 57% to 9.5 million items, whilst cost has decreased by 68% to £24.3 million.

Prescribing of fixed dose combination ACE inhibitor products (i.e. an ACE inhibitor combined with a diuretic or calcium channel blocker) has increased by 28% to 140,000 items, but accounts for just 1% of ACE inhibitor items prescribed. The cost of these products however represents 7% of the total cost of ACE inhibitors, although the cost that fixed dose combination ACE inhibitor products represents has decreased by 31% to £1.8million.

Prescribing of fixed dose combination AIIIRA products (i.e. an AIIIRA combined with a diuretic or calcium channel blocker) now stands at 181,000 items (a 167% increase) and costs have doubled to £4million. Combination AIIIRA products account for 5% of all prescribing of AIIIRAs and 6% of the cost.

### References

1. BNF 58 (2009) BMJ Group and RPS Publishing.
2. RDTIC (2007) ACE inhibitors and angiotensin II receptor blockers in combination. Drug Update 54.
3. NICE (2003) Chronic heart failure: management of chronic heart failure in adults in primary and secondary care. Clinical guideline 5.
4. NICE (2006) Hypertension. Management of hypertension in adults in primary care: pharmacological update. Clinical guideline 34.
5. NICE (2007) MI: secondary prevention in primary and secondary care for patients following a myocardial infarction. Clinical guideline 48.
6. NICE (2008) Type 2 diabetes: the management of type 2 diabetes. Clinical guideline 66.
7. NICE (2008) Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. Clinical guideline 73.
8. CKS (2009) Cardiovascular clinical topics. SCHIN.
9. Micromedex (2009) MICROMEDEX [CD-ROM]. (Vol 135, 3rd Quarter 2009). Thomson Healthcare.
10. Matcher DB, et al. Systematic review: comparative effectiveness of angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers for treating essential hypertension. Ann Intern Med 2008;148:16-29.
11. National Prescribing Centre. Chronic heart failure: overview of diagnosis and drug treatment in primary care. MeReC Bulletin 2008;18 No. 3
12. The ONTARGET investigators. Telmisartan, ramipril or both in patients at high risk for vascular events. New Engl J Med 2008;358:1547-59.
13. Shibata MC, et al. The effects of angiotensin-receptor blockers on mortality and morbidity in heart failure: a systematic review. Int J Clin Pract 2008;62:1397-402.
14. RDTIC (2008) Fixed-dose combinations (Part 2). Drug Update 62.

## Key Messages

**There is no evidence that AIIIRAs are more effective than ACE inhibitors for any indication.**

**AIIIRAs are an alternative choice to ACE inhibitors when an ACE inhibitor is clinically indicated but not tolerated due to a persistent and troublesome dry cough.**

**In a Micromedex review, the incidence of cough in patients taking ACE inhibitors has been reported to be up to approximately 12%. Among patients experiencing cough, between 20% and 60% will rate it intolerable and request withdrawal of therapy.**

**Combined treatment with both an ACE inhibitor and an AIIIRA currently has a limited role, and the risks of worsening renal function and hyperkalaemia are increased.**

**There are few good quality studies which show that fixed dose combination products improve concordance and even fewer which demonstrate improved outcomes with their use.**

## NHS prescription charges frozen

Mike O'Brien, Minister of State, Department of Health announced in March a freeze on prescription charges for 2010-11. The prescription charge will remain unchanged at £7.20 for each quantity of a drug or appliance dispensed.

The cost of a prescription prepayment certificate (PPC) will remain at £104.00 for an annual certificate. PPCs offer savings to those who need frequent prescriptions throughout the year. The cost of the three-month PPC, which is useful for those with a shorter-term need for prescription items, will remain at £28.25.

People can buy or renew their PPC online at [www.nhsbsa.nhs.uk/ppc](http://www.nhsbsa.nhs.uk/ppc) and pay by monthly Direct Debit.

### Did you know?

As a pharmacist you can register to sell PPCs. Log on to <https://www.ppa.org.uk/ppa/ppcdd/PharmacyRegPage.do>

## Women's pension age and prescription exemptions

The state pension age for women (currently 60) will rise gradually from April 2010 until it is equalised with the male state pension age (65) in April 2020. In the Pre-budget Report it was announced that eligibility for pensioner benefits for men and women, such as concessionary travel and free prescriptions, will increase in line with the female state pension age. No one currently receiving these benefits will be affected.

There will be no changes to the age exemption criteria for free prescriptions in April 2010. The Department of Health is considering how best to implement changes to the age at which people qualify for free prescriptions, in line with the changes to state pension age for women.

## Medical Exemption for Cancer Patients

On 1 April 2009 the Department of Health introduced a change to medical exemptions to include those undergoing treatment for:

**(i) cancer; (ii) the effects of cancer; or (iii) the effects of cancer treatment.**

One year on there over 80,000 cancer patients with a medical exemption certificate.

You may wish to inform patients about a medical exemption and that they can apply for medical exemption certificate using application form FP92A (January 2009 revision) which they can get from their GP surgery or oncology centre.