EPS Special feature
Update and top tips

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Pharmacy medicines optimisation role to be key focus of new NHS commissioners

Developing community pharmacy’s role in medicines optimisation will be a key focus for the new NHS commissioners and the sector now has a huge opportunity to get to grips with this role and demonstrate significant successes in it, delegates at the Community Pharmacy Conference 2013 heard last month.

Clare Howard, Deputy Chief Pharmaceutical Officer at NHS England, outlined how the new commissioner of pharmaceutical services would be looking to improve quality, value and outcomes from medicines use in the reformed NHS. This would involve enhanced collaboration between healthcare professionals as well as better engagement with patients and the public, she said.

NHS England will be producing a strategy on medicines optimisation and community pharmacy is likely to have a key role to play. But Clare warned that to succeed in this, community pharmacy will need to grapple with issues such as the measurement of its performance in the reformed NHS. “That is not about volume of activity so how many MURs did you deliver; but it’s what was the impact to the patient;” she explained. “If we’re still here in five to 10 years time with patients still not taking their medicines correctly 50% of the time, there will be some significant questions for the pharmacy profession to have to stand up and answer;” she added.

But community pharmacy was already getting to a place where it could demonstrate the positive impact it is having on patients, Clare said, and she called on pharmacists to take a leap of faith in the new NHS. Pharmacy had seen what such leaps could deliver through schemes such as Healthy Living Pharmacies, she said.

NHS England has not yet shared how pharmacy might be involved in its medicines optimisation strategy, but Clare added that service design in the future would need to involve conversations with patients. "We can no longer develop services where we as pharmacists sit and think about what would be a good idea – we’ve got to have conversations with patients;" she said.

The conference also heard from Deborah Jaines, Head of Outcomes and Primary Care at NHS England. Deborah outlined her vision to ensure consistency across the community pharmacy network so that all patients could have access to “the vibrant and exceptional services that are available in parts of the country”. Achieving this in the NHS could be easier, she said, because there would be 27 outposts of a single organisation (the area teams of NHS England) trying to get the message out rather than more than 100 PCTs.

Deborah also outlined NHS England’s work on developing a primary care strategy. She stressed that the organisation wanted to develop a national framework that would “increase the value that community pharmacy can deliver and enable community pharmacy to do that”. And she said this would involve thinking about topics such as quality improvement, data and transparency, support for innovation and improvement and incentives for contractors.

To see the slides from some of the presentations given at the Community Pharmacy Conference 2013, visit the PSNC website at: www.psnc.org.uk/news.php/1571/community_pharmacy_conference_2013_presentations

Call to action for all pharmacists on medicines optimisation

Medicines optimisation has also been in the news this month as pharmacists and other healthcare professionals have been asked to give their patients more help with their medicines to improve health outcomes and reduce waste.

The call came as the Royal Pharmaceutical Society (RPS) published a document setting out four guiding medicines optimisation principles which it believes all healthcare professionals should adopt.

The principles, which the RPS has asked all those involved in prescribing, dispensing, administering and taking medicines to adopt, are:

- Aim to understand the patient’s experience
- Make sure choice of medicine is made on the best available evidence
- Ensure medicines use is as safe as possible
- Make medicines optimisation part of routine practice

The principles have been developed with a range of organisations representing patients and health professionals and also have the backing of NHS England, the Academy of Medical Royal Colleges, the Royal College of General Practitioners, the Royal College of Nursing and the Association of the British Pharmaceutical Industry.

Welcoming the publication of the principles, Alastair Buxton, PSNC Head of NHS Services, said: “Community pharmacy teams are already working hard to help their patients get the most out of their medicines and to tackle the many challenges we face with medicines use in this country. Advanced services such as MURs and the New Medicine Service can of course make a real difference, but pharmacy teams will also be helping on a day-to-day basis outside of these, answering patients’ queries and ensuring they know how to take the medicines they are given.

“These four principles give a very useful focus to that work and applying them will certainly help pharmacists and other healthcare professionals to ensure they are taking every opportunity to optimise the use of medicines in partnership with patients,” Alastair continued. As well as doing this, PSNC would encourage LPCs and community pharmacists to seek out opportunities to be involved in leading the medicines optimisation agenda at a local level, for example through the new commissioning structures.
Pharmacy must use NHS restructure to remove blocks to progress, PSNC CEO tells conference

The “revolutionary changes” being made to healthcare must be used to overcome some of the barriers to the development of community pharmacy services, PSNC Chief Executive Sue Sharpe told LPCs, contractors, charities and commissioners at the Community Pharmacy Conference 2013 last month.

Three and a half weeks into the new commissioning environment, Sue described the impact the changes have had on DH resources and PSNC negotiations, and set out a vision for pharmacy’s role in the new NHS.

PSNC believes that there are massive opportunities for both community pharmacies and their commissioners in public health and prevention. Pharmacies must become the key resource in ensuring that the specialist skills and resources elsewhere in the NHS are used effectively, helping people to manage their own health and conditions, and helping to achieve integration of health and social care.

Although there have been real successes in developing pharmacy’s role in recent years – for example through MURs, the New Medicine Service and supplementing the diagnostic and prescribing roles of GPs and specialists – progress has been constrained by a lack of support in primary care, lack of confidence to invest to expand services and lack of funding for pharmacy services. “This has some elements of a vicious spiral. Unless we unblock these constraints the NHS will not be able to get full value from pharmacies, so we must use this restructuring to do this unblocking,” Sue told conference delegates.

PSNC will continue to work with LPCs in the reformed NHS to support good commissioning and sharing of information about innovative practices as well as facilitating communication and local service development. The committee will also be pressing the case for community pharmacy, working to try to ensure that NHS England’s eyes and ears are open and to ensure they are determined to use the opportunities to develop pharmacy services.

The Community Pharmacy Conference 2013 also heard from Jeannette Howe, Head of Pharmacy at the Department of Health (DH), about the role the department will play in the reformed NHS and how it will work alongside NHS England on pharmaceutical services. The diagram below sets out some of the key organisations that will have an influence on pharmacy in the new NHS and shows that the DH will in future determine NHS product reimbursement for pharmacies, continuing to set prices for drugs and appliances. Meanwhile NHS England will commission pharmaceutical services, determining the service remuneration for Essential, Advanced and Enhanced services, plus Local Pharmaceutical Services. This means that both organisations are currently involved in negotiations on the community pharmacy funding settlement, as both have an influence on different aspects of pharmacy payments. Alongside this work, the DH will maintain responsibility for setting national healthcare priorities, setting the policy and legal frameworks for health services and accounting to Parliament for the effectiveness of the systems; while NHS England has responsibility for determining funding for the other primary care professions.
Need help with the new PharmOutcomes?

If your pharmacy is using the new PharmOutcomes system to manage locally commissioned services and you need support on its use, or have lost your password, visit the Help section at www.pharmoutcomes.org.

Within the help section you can access FAQs, user guides for the system and specific services, request a new password and send a message to the helpdesk requesting further support.

NMS IT support still available

The original PharmOutcomes platform included a module that supported provision of the New Medicine Service (NMS). That platform was closed on 10th April 2013, but Health Information Exchange and its IT partner for the original PharmOutcomes platform, Crimson, reached an agreement in March 2013 on a license which allows Crimson to use the PharmOutcomes NMS module on their myhealthplace platform.

If pharmacy contractors wish to use the NMS module, they can do this for a payment of £5 per pharmacy per month. Contractors should email myhealthplace@crimson.co.uk for further information, or to set up access to the NMS module on the myhealthplace platform.

Developing consultation and communication skills for pharmacists and pharmacy technicians

In March Modernising Pharmacy Careers (MPC), a programme of Health Education England (see box, opposite page), hosted a meeting to start work on developing and assuring the consultation skills of pharmacists and pharmacy technicians to support medicines optimisation and the delivery of public health messages.

The meeting, which was chaired by Professor Christopher Cutts, Director of CPPE and Clare Howard, Deputy Chief Pharmaceutical Officer, NHS England, was attended by stakeholders across a range of different pharmacy sectors and job roles.

Participants discussed their visions and aspirations for developing consultation skills in pharmacy professionals. In breakout sessions, participants shared ideas about what they thought the ‘perfect model’ for learning, experience and assessment of consultation skills would look like, then discussions turned to possible barriers to achieving the perfect model, and, finally, considered how such barriers could be overcome.

This work came about as a result of proposals issued by Health Education England’s Modernising Pharmacy Careers professional board in 2012 to help strengthen and develop the confidence and skills of pharmacists and pharmacy technicians post registration. The proposals included the need to enhance the skills of pharmacy professionals in working with patients, other healthcare professionals and members of the public to improve the safety, value and effectiveness of medicines through medicines optimisation and to enhance their skills in the delivery of public health interventions.

Following the success of the initial brainstorming meeting, a Task and Finish Group and Reference Group have been set up to progress this piece of work. The Task and Finish Group will make recommendations for a national model for enhancing the consultation and communication skills of pharmacists and pharmacy technicians. Meetings of the group will take place over the coming months, with delivery of outputs planned for the autumn.

Further information regarding the MPC programme and the proposals to develop post-registration pharmacy career development can be found on the HEE website (www.hee.nhs.uk).

Commenting on the importance of this programme of work, Alastair Buxton, Head of NHS Services, PSNC said: “High quality conversations with patients mean effective consultations and positive outcomes; all pharmacy professionals need to be supported to ensure they have the required communication skills in order that the profession can fully play its part in medicines optimisation.”

Christine Burbage, superintendent pharmacist at Superdrug and PSNC member said: “It is really important for the profession that we don’t waste time – we need to make this happen.”

RPS Commission on Future Models of Care

In mid-April the Royal Pharmaceutical Society launched their Commission on the Future models of Care, which has been initiated by the English Pharmacy Board. The Commission will bring together expertise from across pharmacy, the wider health care sector, and patients and the public to develop practical ideas about how future models of care can be
What is Health Education England (HEE)?

The establishment and development of HEE was set out in ‘Liberating the NHS: Developing the Healthcare Workforce, From Design to Delivery’, the Government’s policy for a new system for planning and commissioning education and training. The driving principle for reform of the education and training system is to improve care and outcomes for patients.

It was established as a Special Health Authority in June 2012, taking on some functions from October 2012 before assuming full operational responsibilities from April 2013.

HEE will provide leadership for the new healthcare education and training system, ensuring that the shape and skills of the future health and public health workforce evolve to meet changing demands placed on the health and care system. It will ensure that the workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare.

It will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards (LETBs), which are statutory committees of HEE. There are 13 LETBs across England that are responsible for the training and education of healthcare staff within their area. The LETB boards are made up of representatives from local providers of NHS services, which could include community pharmacies; a number of LPCs are already developing relationships with their LETB in order to ensure community pharmacy and primary care training and development features in the work of the LETB.

The key national functions of HEE include:

- Providing national leadership for planning and developing the whole healthcare and public health workforce;
- Authorising and supporting development of Local Education and Training Boards and holding them to account;
- Promoting high quality education and training which is responsive to the changing needs of patients and communities and delivered to standards set by regulators;
- Allocating and accounting for NHS education and training resources – ensuring transparency, fairness and efficiency in investments made across England;
- Ensuring security of supply of the professionally qualified clinical workforce;
- Assisting the spread of innovation across the NHS in order to improve quality of care; and
- Delivering against the national Education Outcomes Framework to ensure the allocation of education and training resources is linked to quantifiable improvements.

delivered through pharmacy over the next few years.

The report of the Commission, to be made in Autumn 2013, will suggest how policy makers, commissioners and the pharmacy profession can put into practice such new models of care. The Commission is being chaired by Dr Judith Smith, Director of Policy at the independent charitable research foundation, the Nuffield Trust.

The terms of reference for the review are to:

- make the case for change in relation to the role that pharmacy can play in the delivery of care;
- articulate the benefits to patients of involving pharmacists in the delivery of a wider range of services;
- identify the range of models of care involving pharmacy that are starting to emerge in the UK and overseas;
- examine what has helped or hindered the development of such models of care;
- identify what needs to be done to enable and support the spread of such models of care; and
- consider the implications of the commission’s findings for policy and practice in the English NHS and more widely.

It is hoped that the ‘non-pharmacy’ input into the review will support a wider dissemination of the eventual findings than would be possible for an inward looking exercise within the profession, however the bulk of the information on current innovation in pharmacy needs to come from the profession itself.

PSNC has already had a one-to-one session with Judith Smith to explain our vision for future service development and we will be contributing further views and examples of innovative practice as part of the evidence gathering process. PSNC has also encouraged LPCs to submit examples of innovative services that have developed in their area over the last two to three years.

Further information on the Commission can be found at www.rpharms.com/futuremodels
PSNC has been concerned to hear reports from pharmacies that Quintiles have been requesting access to confidential prescriber and sensitive patient data from patient medication records in order for pharmacies to adjust their allocation of medicines under manufacturer-imposed quota arrangements. PSNC has been in contact with Quintiles who have stated that the audit serves a dual purpose: to ensure pharmacies have accurate information about their stock requirements, and to ensure the drug manufacturers have accurate information concerning pharmacy stocking requirements. Quintiles describe this as a free of charge, (i.e. funded by the pharmaceutical supplier) legitimate service facilitating these mutual objectives.

Patient medication records, which contain the patient’s sensitive data, are amongst the most confidential matters that pharmacies handle. Patients, the Information Commissioner and the NHS would expect their disclosure only where explicit consent has been given, or in the absence of consent, where there is an over-riding provision to allow lawful disclosure.

The arrangements in question, so far as we understand them, are that a nurse employed by Quintiles would visit the pharmacy to examine the records. An ‘honorary’ contract is signed between the contractor and the nurse, purporting to employ the nurse for the duration of their visit. It has been suggested that this would allow the nurse to have access to the same information as any other member of staff. Quintiles stress that the nurses have professional as well as contractual obligations of confidentiality, and that the ‘honorary contract’ is in fact a legally binding tri-partite agreement between Quintiles, the nurse and the pharmacy.

PSNC believes that such an arrangement to allow access to individual patient records, without explicit patient consent on the grounds that pharmacy employees would normally have access to the PMRs would not be acceptable to the Information Commissioner or the NHS. But we also question whether even a member of staff would have a right to examine the medication record for an individual patient for a purpose such as this, which is unrelated to the treatment of that individual patient. We do not believe that it would be justifiable for the pharmacy to disclose a patient’s sensitive information to a third party to satisfy an audit of stock usage, carried out on behalf of a manufacturer.

We have raised our concerns with Quintiles, and they have agreed that their auditors will not in future request to see any patient identifiable information. They will, however, request evidence from the PMR of the dispensing of the drugs they are auditing. Pharmacists will need to ensure that during this process, there is no disclosure of patient’s details (such as name or address). Disclosure of the details of prescriptions dispensed, omitting patient data, would be acceptable.

Quintiles has also indicated that it wishes to see details of the prescribers of the items that they are auditing. Practice level prescribing information is publically available, but prescribers may consider that their individual prescribing should be treated as confidential information, and not be disclosed to an auditor funded by a pharmaceutical supplier. Pharmacists who are to be visited by an auditor may wish to seek the views of the local prescribers before deciding whether to allow access to individual prescriber details.

Quintiles have also advised that they will continue to work with an Honorary Contract, which they believe makes clear their obligation not to disclose any sensitive information their audit staff may come across in the course of their audit work. PSNC is not supportive of this system, and reminds contractors that the clinical governance requirements in the terms of service impose significant obligations on contractors when they employ or engage staff – such as checking registration and qualifications, taking up references, supporting CPD, identifying training needs, providing training on safeguarding, Information Governance (including confidentiality), and the SOPs in use in the pharmacy. To protect any confidential information that may be seen during the course of the audit (for example, prescription volume, or overheard conversations about the clinical care provided to patients) the contractor may instead prefer to enter into a direct confidentiality agreement with Quintiles and their representative – but this is a matter for contractors.

There is good practice guidance agreed for products in short supply, to allow manufacturers and pharmacies to reach agreement over the supply of stocks subjected to quotas, but this does not include any requirement to disclose sensitive information.

For further information please refer to:

- PSNC Information governance web page: http://www.psnc.org.uk/IG

**PSNC E-NEWS**

To receive a weekly summary of the latest news and guidance featured on the PSNC website including pharmacy contract news, Drug Tariff News, NCSO updates, events information and much more, sign up to receive PSNC’s weekly e-newsletter. Visit www.psnc.org.uk/enews to register
Changes to the GMS contract in 2013/14 – Implications for pharmacies

Following negotiations between the GP Committee (GPC) of the BMA and NHS Employers, the Department of Health (DH) consulted on proposals to change the primary medical care contractual arrangements in December 2012.

The GPC and other medical stakeholders raised a wide range of objections to the changes proposed by DH, but in March this year DH determined that the changes would be implemented by NHS England, with a number of amendments being made following feedback from the GPC and others. The main changes to the service elements are amendments to the Quality and Outcomes Framework (QOF) and the introduction of new Enhanced services.

New Enhanced services

Four new Enhanced services are being introduced into the contract, funded by the retirement of the QOF organisational measures. The new services are:

1. The identification and case management of patients identified as seriously ill or at risk of emergency hospital admission. This will be undertaken by risk profiling and stratification of their registered patients on at least a quarterly basis. For patients identified by this process the practice should coordinate the care management of those patients who would benefit from more active case management. It is likely that the CCG will have a significant interest in this service and may coordinate the work across its practices.

2. Undertaking a proactive approach to the timely assessment of patients who may be at risk of dementia. This will be based on an opportunistic offer of assessment to at-risk patients who are aged 60 and over with CVD, stroke, peripheral vascular disease or diabetes; patients aged 40 and over with Down’s syndrome and other patients aged 50 and over with learning disabilities; and patients with long term neurological conditions which have a known neurodegenerative element, for example, Parkinson’s disease.

3. Undertaking preparatory work in 2013/14 to support the subsequent introduction in 2014/15 of remote care monitoring arrangements for patients with long term but relatively stable conditions. This will involve agreement with the CCG which long term condition is to be the local priority for remote care monitoring in 2014/15. The appropriate test or bodily measurements required to support the stable management of the chosen condition will be agreed alongside how the tests and measurements will be accessed or fed in by patients. The options by which patients will receive results of the tests or measurements, other than by face to face consultations, will be identified, e.g. video call, telephone, text, email or letter. Practices will then discuss the opportunity to use this service in the following year with appropriate patients.

4. Enabling patients to use electronic communications for booking of appointments and requesting repeat prescriptions. NHS England intends to develop the service in 2014/15 to take into account the Government’s commitment for implementing secure online communication and viewing medical records (including test results and letters).

The latter service is of most immediate interest to LPCs and community pharmacy, as pharmacy contractors will want to understand the local process to be used for the ordering of repeat prescriptions and the ramifications this may have for current pharmacy practice and the potential for this development to prompt changes in GP practice procedures or behaviour related to collection of repeat prescriptions. PSNC suggests that all pharmacy contractors ascertain whether local GP practices plan to implement the service and if they do plan to implement it, how this will take place. Contractors should then assess what implications this has for their pharmacy systems, e.g. will changes to repeat prescription collection systems need to be made.

The other services are not likely to have such an immediate impact on community pharmacy, but the widespread adoption of risk profiling and stratification of patients, especially if this is conducted at a CCG level, may provide opportunities for promotion of community pharmacy medicines optimisation services such as MUR and NMS and their more effective integration into local care pathways (e.g. using risk stratification data to prompt GP referrals to the MUR service for certain patients). PSNC has suggested to LPCs that they may want to keep an eye on such developments in order that they can highlight to CCGs the support community pharmacy can provide to high risk patients.
The dementia service will sit alongside other local initiatives to support the early identification and management of people with dementia, such as the introduction of a dementia element to the NHS Health Check service, which local pharmacies may be providing. There has been comment in the medical press that suggests that this service is less favoured by some GPs, due to the potential workload it may impose on practices.

The introduction of remote care monitoring arrangements will be phased over two years, so there may be minimal immediate implications for community pharmacy, but LPCs and contractors will be able to see the potential for community pharmacy to be involved in supporting the provision of such monitoring. This was also noted by Deborah Jaines, Head of Outcomes and Primary Care in NHS England’s commissioning development directorate, when she commented at the recent PSNC Community Pharmacy Conference that she was keen to explore the opportunities for extension of remote care monitoring into community pharmacy.

Quality and Outcomes Framework (QOF)

DH proposed a number of changes to the Quality and Outcomes Framework (QOF) in order to secure further health improvements for patients. These included implementing all the NICE recommendations for changes to QOF (NICE became responsible for managing an independent and transparent approach to developing the QOF clinical and health improvement indicators from April 2001); raising thresholds for existing indicators in line with the 75th centile of achievement to ensure more patients receive evidence-based care; setting up a Public Health Domain in the QOF, as originally proposed in the 2010 Public Health White Paper; and removing the remaining organisational indicators that represent basic standards that all practices will be expected to meet as part of CQC registration.

A summary of the QOF, including the new and amended indicators is available on the NHS Employers website (www.nhsemployers.org). The new indicators relate to management of heart failure, hypertension, diabetes, COPD and rheumatoid arthritis.

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PSNC has issued an update about its ongoing work on price concessions and reminded contractors of the need to challenge suppliers charging prices that are above the agreed concessionary prices and to send invoices to PSNC where those higher prices are still charged.

**Background**

In recent months shortages have become a more significant problem for contractors, in part because an increasing number of high volume generic products have been affected. Manipulation of the market is also making the situation increasingly complicated and appears to be having a significant impact in some regions.

PSNC has been working hard to secure appropriate NCSO/price concessions for contractors where lines are not available at the Drug Tariff price as a result of a shortage. Concessionary prices are set by the DH, but we continue to challenge the DH where we do not believe these prices reflect actual market prices or do not have evidence that there are significant amounts of stock available at or below the concessionary prices.

It is vital that contractors continue to challenge wholesalers where they are charging prices that are significantly above concessionary prices. Although we know that most wholesalers would not do this, we have received reports of some wholesalers deliberately inflating prices and informing contractors that NCSO will be granted. We also know that some contractors have successfully challenged high prices.

**Pricing information**

PSNC has been asked by some contractors to publish pricing information given to us by wholesalers. Publishing lists of some suppliers’ prices could result in us being legally challenged for breach of Competition law, so we are not able to do this.

**Ongoing work**

PSNC continues to work hard to reach agreement on price concessions as early as possible each month but given the limitations of the current model this is not always possible and we are in urgent discussions with the DH to find a longer-term solution to deal with generic shortages. Our aim in these discussions will be to find solution that is both fair for all contractors and that will minimise the opportunities for market manipulation.

Evidence from contractors’ invoices continues to be a vital part of this work, and where contractors are being charged prices that are higher than the agreed concessionary prices, we would urge them to challenge their wholesaler, and if this is not successful, to send copies of their invoices to us.
Seven pharmacy systems have EPS Release 2 full roll-out approval, AAH Proscript Link, Cegedim Nexphase, Cegedim Pharmacy Manager, Helix Health QicScript, Positive Solutions Analyst, Rx Systems Proscript and the Lloyds Compass system.

Four GP systems, EMIS Web, InPractice Vision, TPP SystmOne and Microtest Evolution 11 have been granted EPS Release 2 full roll-out approval. EMIS users need to migrate from the EMIS legacy solutions, EMIS LV and EMIS PCS to EMIS Web before being able to access Release 2.

### EPS Deployment Update

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<tr>
<th>EPS Release 2 Deployment Statistics (Extracted 26th April 2013)</th>
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<tr>
<td>EPS R2 enabled GP practices</td>
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<td>(Information on planned individual GP deployments available at: <a href="http://www.hscic.gov.uk/EPS">www.hscic.gov.uk/EPS</a>)</td>
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<tr>
<td>EPS R2 enabled pharmacies</td>
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<tr>
<td>Number of R2 prescription messages to date</td>
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<td>Number of patient nominations set</td>
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### Coming soon: EPS Online Prescription Tracker

A problem reported by EPS Release 2 sites has been patients arriving at the pharmacy but their electronic prescription is not there as expected. There are a range of possible reasons for this, for example,

- the GP not having issued the prescription,
- the prescription being post-dated so it has not yet left the GP system or
- if it is a repeat dispensing prescription, the next issue may not have been pulled down from the spine via the automatic scheduling functionality as expected.
- whilst rare, there may also be technical reasons that have delayed the arrival of an electronic prescription.

To support troubleshooting in pharmacy and GP Practices, the HSCIC have developed a simple, “Where is my prescription?” online tracker that can be used to confirm the location of an electronic prescription passing through the EPS Service. Expected to be launched shortly, it will be accessible online to pharmacy and GP practice staff with smartcards.

More information will be posted on the PSNC website as soon as it becomes available (www.psnc.org.uk/EPS).

### The Future of the ‘Spine’

The NHS contract with BT to provide the Spine ends in April 2014. From September 2013, management of the central EPS system infrastructure will transfer from BT to under the direct control of the EPS team with the support of a software partner. This change has the potential to offer increased flexibility to make changes to the EPS functionality.

The first release of the new Spine will be like-for-like with the current Spine; enhancements are expected to start being made to the EPS service from 2014. Enhancements under consideration include moving to a ‘push’ versus ‘pull’ model for the transmission of acute prescriptions to the patient’s nominated pharmacy and enhancing the repeat dispensing functionality to improve the logic that enables automated download of the next prescription issue.

### EPS & the NHS Re-organisation

On the 1st April 2013, NHS Connecting for Health closed, and many of its functions, including the Electronic Prescription Service, were transferred to the new Health and Social Care Information Centre (HSCIC). The new website address is: www.hscic.gov.uk/EPS.

Responsibility for supporting pharmacies in accessing and using EPS has been transferred to NHS England. Information on changes to local arrangements such as changes to local processes for obtaining smartcards and tokens is available from LPCs.
EPS Endorsing and Submission

Top Tips for endorsing & submitting EPS
Release 2 prescriptions

As with paper prescriptions, errors or omissions in the endorsing and submission of electronic prescriptions can lead to incorrect payment. PSNC has been working to identify and monitor possible risk areas; key areas to be aware of are:

Exemption information
Every electronic prescription must be marked to indicate whether a prescription charge was levied.
NHS Prescription Services do not review the patient exemption declaration on tokens when calculating payment. If the exemption information is not recorded correctly in the electronic claim message by pharmacy staff, the pharmacy could be paid incorrectly. Note, there are controls in place at NHS Prescription Services to ensure that charges are not deducted for age-exempt prescriptions and exemptions for products listed in the ‘No Charge Contraceptives’ section of Part XVI of the Drug Tariff.
Tip: Discuss with your PMR provider how your system can support staff completing this information accurately. Does your system support auto-populating exemption information where the patient holds a valid exemption certificate and staff have recorded this information in the patient record? Does your system alert staff when a patient’s recorded exemption status is about to expire? Does your system prevent a claim being transmitted if the prescription charge status is unconfirmed? Does your system generate audit reports showing prescriptions dispensed against exemption status?

Product information in the dosage instructions
Prescribers sometimes include supplementary product information such as a brand name as part of the dosage instructions rather than as part of the name of the prescribed product. Payment of electronic prescriptions is based on the product code of the prescribed product; any additional instructions included in the dosage instructions will be ignored.
Tip: Where the prescriber has added supplementary product information in the dosage field, the prescription must be cancelled by the prescriber and a new electronic prescription generated using the correct product code.

NCSO
Once an electronic reimbursement claim has been submitted, it cannot be amended therefore to ensure correct payment, any endorsements such as ‘NCSO’ need to be made before the electronic claim is submitted to NHS Prescription Services.
Tip: NCSO endorsements can be made for any product in advance of a decision being made by the Department of Health on granting the concession.
Tip: Submission of electronic claim messages could be delayed until month end, however high volumes of claims being sent at this time risks network problems.
Tip: Can your PMR system search for unclaimed messages for a particular product? Can your system search for items where endorsements might be incomplete?
This is one of a number of problems with the current NCSO arrangements; PSNC is reviewing how to deal with shortage lines with the Department of Health.
Timely submission of electronic reimbursement claims
Ensure all electronic prescriptions are claimed for in a timely manner; not doing so could result in delays to payment.
Tip: Does your PMR system alert you to any outstanding claims? Does your system allow separate on-screen display or filtering of prescriptions which have been handed out compared to those awaiting collection, so you can identify those prescriptions which are ready to claim?
Tip: Don’t forget to include the electronic prescriptions dispensed plus your paper prescriptions when declaring the number of forms and items on the FP34c submission form. This will ensure you receive the correct advance payment.

Prescriber endorsements
Common prescriber endorsements which impact on reimbursement and remuneration include ‘SLS’ (assorted flavours) and ‘CC’ (contraceptive medication). EPSR2 prescriptions include a dedicated ‘prescriber endorsement field’ for the inclusion of this information in electronic prescriptions. Pharmacies could miss out on accurate payment if the prescriber endorsement is missing or if the endorsement has been included in the dosage instructions field rather than in the dedicated prescriber endorsement field on the electronic prescription.
Tip: Are you able to clearly identify where information in the prescriber endorsement field appears on-screen using your PMR system? If not, ask your PMR provider to make this clearer or alert you if a product may require a prescriber endorsement but this hasn’t been included in the prescriber endorsement field.

This Month’s EPS Top Tip: Purchasing a Printer for Dispensing Tokens

Check with your supplier before buying a new printer to ensure that your preferred model is compatible with printing on the A5 size FP10DT form. Purchasing a printer other than one recommended by your supplier could result in additional costs if problems are experienced during printer set-up.
EPS Training

One of the biggest lessons learned from early adopters of EPS Release 2 is the need for staff to have adequate and timely training. Although it is still early days in the national deployment of EPS Release 2, problems have already arisen that are directly attributable to either inadequate training or the absence of training.

Different suppliers are offering a range of different training methods and materials, as outlined in the table below. It is important to work with suppliers to ensure that training is sufficient and meets the needs of individual staff.

### EPS Training Matrix

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<th>Supplier / System</th>
<th>Training Method</th>
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<tbody>
<tr>
<td>Cegedim / Pharmacy Manager</td>
<td>Face to face training (optional)</td>
<td>Workbook, e-learning / simulation videos, Webinar, Support documentation</td>
</tr>
<tr>
<td></td>
<td>Webinar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e-learning</td>
<td></td>
</tr>
<tr>
<td>Cegedim / NexPhase</td>
<td>Face to face training (optional)</td>
<td>Workbook, e-learning / simulation videos, Webinar, Support documentation</td>
</tr>
<tr>
<td></td>
<td>Webinar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e-learning</td>
<td></td>
</tr>
<tr>
<td>Rx Systems / ProScript</td>
<td>Face to face training</td>
<td>PowerPoint presentation (incorporated e-learning), Training manual, Quick reference guides</td>
</tr>
<tr>
<td></td>
<td>Webinar – being considered not confirmed</td>
<td></td>
</tr>
<tr>
<td>Helix / QicScript</td>
<td>Face to face training</td>
<td>Training manual, e-learning</td>
</tr>
<tr>
<td></td>
<td>e-learning</td>
<td></td>
</tr>
<tr>
<td>Positive Solutions / Analyst</td>
<td>Face to face training e-learning</td>
<td>e-learning, Training manual, Quick reference guide, Video, Online helpfiles</td>
</tr>
</tbody>
</table>

Source: HSCIC Website ([www.hscic.gov.uk/eps](http://www.hscic.gov.uk/eps))

### Training – Top Tips from EPS R2 Users

- Find out what kind of training your system supplier is offering. For example one to one staff training, the provision of a training environment, webinars, training videos, user manuals, quick reference guides and/or desk aids and help files on the system.
- Make sure that you take time to read any information packs you receive from your supplier as these could contain links to manuals, videos or dates of Webinar sessions.
- Planning is a must - consider setting out a plan with a rough timetable outlining who will be available and when. Don’t forget part time staff and locums.
- Different staff will have different training needs. For example, counter staff may need to understand the nomination functionality but not how to submit a reimbursement claim. Training needs to be relevant to an individual’s role.
- If the pharmacy is going-live well in advance of receiving electronic prescriptions, consider whether it is better to deliver training in two stages with basic training on the go-live day and more in-depth training at the point that the pharmacy starts receiving electronic prescriptions. The key is to ensure that messages are delivered at the time they are required.
- Where pharmacies have captured large volumes of nominations prior to a local surgery going live, this has enabled staff to cement business process change early. Where low numbers of nominations are recorded, the re-education of staff to new processes has been slower.
- Where e-learning is being considered as an option, ensure that the computers in the pharmacy are capable of accessing and running the e-learning module - including playing any videos and sound.
- Communicate with local GP Practices and discuss business processes before go live such as how split prescriptions will work, using repeat dispensing and cancellations.
- Whilst locums may have received training in system functionality at another pharmacy, business processes are unique to every pharmacy so ensure locums are briefed on these changes.
- All staff should be made aware of the helpdesk process for system issues – make sure the contact details are easily accessible for staff.

More detailed information and tips on planning EPS R2 training can be found on the PSNC website ([www.psnc.org.uk/r2](http://www.psnc.org.uk/r2)).
This month Dr Dhiren Bhatt, independent community pharmacy contractor, member of the PSNC Funding and Contract Subcommittee and PSNC regional representative for East Anglia, discusses the challenges ahead and explains why he believes all pharmacies need to focus on clinical engagement with patients.

Why did you decide to stand for election onto PSNC?
As an independent pharmacy contractor I was motivated to become a member of PSNC because I wanted to be actively involved in shaping the future direction of our profession. The unique position of PSNC is that all pharmacy contractors are truly represented within it – the committee has 13 regionally elected independent contractors; 12 representatives of large multiples as well as three from non-CCA multiples; and the NPA and Wales representatives. We all come from very different businesses but our collective expertise combined with a strong executive leadership, enables PSNC to make difficult decisions, based upon robust governance, in order to advance the interests of community pharmacy contractors.

You’ve been a member of PSNC for more than ten years – have there been any highlights?
The obvious one was having the privilege to be part of the Negotiating Team that worked on the new community pharmacy contractual framework that was introduced in 2005. That framework saw a fundamental change in our relationships with the NHS and has in my view positioned community pharmacy well to develop further in the coming years. Our policies have consistently supported innovation and collaboration.

Another highlight has been our work locally and nationally on the agreement PSNC reached with the Department of Health and the Dispensing Doctors’ Association over rural dispensing arrangements. The agreement took a long time in the making and finally came into force in 2005, but it laid to rest many of the very difficult and acrimonious local decisions that had previously been required over rural dispensing.

What is your favourite thing about being a community pharmacist? The most rewarding part of pharmacy practice for me is when we succeed with our patients. In particular I am a great advocate of the MUR service, not surprisingly as I was part of the Negotiating Team that developed the service and introduced it as part of the contractual framework, but throughout my pharmacy career I have maintained my interest and expertise in clinical pharmacy services. I also have an interest in postgraduate training and research. We have now begun to collect some of the valuable evidence we need for future service development, particularly for medicines optimisation and further to improve drug therapy. All this depends upon clinical engagement and we must remain united in this purpose to have a real impact.

Are you optimistic about the future of community pharmacy? There is a harsh reality within all professions, and particularly those in the public sector, in these times of financial austerity; the environment makes everyone very susceptible to the risks that we already had within our businesses. However, twenty eight years in community pharmacy as an independent contractor have taught me that pharmacy is extremely resilient – our core services are very highly valued by the public and as long as we keep focused on delivering a quality service we will have much to build upon and much to offer when the financial environment begins to improve.

I share the frustration of my colleagues in relation to funding but it is vital we take the time needed to negotiate the best possible outcome in this year and also set robust parameters for future years. The NHS reforms have of course presented a challenge because they have imposed on us a multitude of new commissioning bodies and key organisations that we now need to influence and negotiate with. In particular I have mixed views about the current arrangement of Local Professional Networks which lack definition but appear to be the only way through which we can influence the local operational networks set up by NHS England ie the Area Teams. But pharmacy is adapting – LPCs are re-examining their functions and forming federations or even merging in some cases to make sure they are improving efficiencies and securing the best value for contractors. And all of this resonates with PSNC’s committee members’ in terms of the support and value we can offer for contractors at a national level.

Do you have any advice for other independent contractors in these difficult times? The challenges at the moment affect all community pharmacy businesses but of course there are certain specific issues that relate to independent businesses. Some of these are around reimbursement and the averaging system and at PSNC we are trying to find innovative solutions to enable more consistent distribution of the funding available.
For now, in my own pharmacy, service and delivery are at the core of everything that we do. My practical advice would be that everyone needs to look at cost efficiencies and skill mix, but we also need to make sure we are using the tools that we have available to us. Take advantage of the support provided by PSNC, the many good LPCs, and other organisations – these are valuable resources.

We also need to see pharmacy building on our core strengths and improving the quality and consistency of our service delivery – we are still not achieving full delivery of services such as MURs and the New Medicine Service, for example.

Pharmacy is well positioned to start meeting some of the big unmet health needs of the population – we have shown this very clearly through initiatives such as the Healthy Living Pharmacy and influenza vaccination – but we need to be able to grasp all the opportunities offered to us.

London pilot MUR shows benefits of extended pharmacy role

A pilot MUR scheme run through ten community pharmacies in London has shown the positive impact that community pharmacists can have in the treatment of people in pain.

The pilot evaluation saw pharmacists who had attended a half-day training session perform 176 specially designed pain MURs over a six-week period.

The pharmacists used patient questionnaires to form the basis of discussions with the aim of identifying patients who were not using their medicines to optimum effect or were, or were at risk of, suffering avoidable side-effects or not obtaining satisfactory pain relief.

During the pilot, 182 interventions were made (because some patients received more than one) with 12 per cent of patients referred to their GP to address side effects; 11 per cent referred because the pharmacist felt enhanced pain relief or another medication change was desirable; and five per cent referred because it was likely they were suffering undiagnosed neuropathic pain.

The researchers concluded that if the scheme were scaled up to a national service, community pharmacies could identify 50,000 more cases of neuropathic pain a year.

“This ought in certain instances – such as the management of recurrent headaches – to reduce counter-productive self-purchased and/or prescribed medicines use,” the researchers from the UCL School of Pharmacy and the University of Nottingham said. They concluded that extending the role of community pharmacists in pain management could lead to better outcomes and help increase the cost effectiveness of NHS care.

Sanjay Ganvir, chair of Camden and Islington LPC, was involved in setting up the scheme, working with the universities and Pfizer, who provided some funding. “This was a brilliant example of pharmacy, academia, an LPC and some innovative community pharmacists coming together to produce some fabulous patient outcomes,” he says.

The scheme received excellent patient feedback, says Sanjay, with GPs also positive when the service had been launched.

“The idea was to produce some nice evidence for the role that community pharmacies can play, and now that we have done that we need to make sure the right people know about it so we can try to get the scheme extended. As a sector we’re trying to demonstrate our key role in medicines optimisation and this is a great example of a way in which we can do that,” he adds.

More MUR News:

Devon LPC develops diabetes ‘MUR plus’ scheme

Devon LPC is preparing to launch an ‘MUR plus’ pilot focusing on diabetes later this summer. The scheme will be open to pharmacies in Plymouth that are currently working towards Healthy Living Pharmacy status, and the LPC hopes the MURs will improve outcomes for diabetes patients and help them to manage their own conditions. The LPC is also working on an evaluation toolkit for the pilot to try to capture the outcomes from it.

Has your LPC worked on an MUR plus scheme?

PSNC is always interested to hear about new MUR schemes as well as any evidence for the success of any existing schemes.

Please email your news on MUR or other local services to zoe.smeaton@psnc.org.uk or mike.king@psnc.org.uk

Want to find information on a particular service?

On the services database page of the PSNC website click on the search button to find details of local services across the country.

Want to share details of a service?

If you have developed or implemented a service in your area and would like to share the details including any documentation with PSNC and LPCs then you can upload the information to the online services database by clicking ‘submit information on a Local Service’.
Further evidence of the difference that community pharmacies can make in improving the health and wellbeing of local communities has been published as part of an evaluation of the Healthy Living Pharmacy (HLP) scheme. The evaluation answered the key question of whether the early results seen in Portsmouth could be replicated in other areas of the country with different demography and geography.

The evaluation looked at service data and patient and pharmacy surveys from community pharmacies in 14 of the 20 pathfinder areas across England. It considered a range of services including stop smoking services, emergency hormonal contraception, minor ailments, alcohol awareness, MURs, NMS and substance misuse services.

The evaluation showed that the HLP concept was consistent with increased service delivery and improved quality measures and outcomes, and that the benefits of the scheme were not dependent on levels of local health need and deprivation. More people successfully quit smoking in HLPs than did so in non-HLP pharmacies, and HLP pharmacies had higher MUR and NMS activity levels.

Key findings included:

- 21% of people surveyed wouldn’t have done anything if they hadn’t accessed a service or support in the HLP so would have missed out on the benefit of getting advice to improve their health and well-being;
- 60% of people surveyed would have otherwise gone to a GP;
- Public feedback was positive with 98% saying they would recommend the service to others and 99% were comfortable to receive the service in the pharmacy;
- More people successfully quit smoking in HLPs than non-HLPs or prior to becoming a HLP;
- The number of people who accessed sexual health services and were provided with additional sexual health advice was greater than in non-HLPs;
- The acceptability of community pharmacy as a location for clients to receive an alcohol service and the relatively high levels of activity seen in HLPs compared with non-HLPs showed that HLPs could have an important contribution to this harm reduction service;
- HLPs were effective at delivering increased support for people taking medicines for long term conditions, through both Medicines Use Reviews and the New Medicine Service. Activity was higher for both services in HLPs than non-HLPs or before HLP implementation in all but one site; and
- Pharmacies were also positive about the scheme, with 70 per cent of the contractors surveyed saying it had been worthwhile for their business.

The full evaluation and further information can be found at www.psnc.org.uk

“Pharmacies have a major role to play in helping improve the public’s health, with 1.8 million people visiting a pharmacy each day. On Monday [April 22nd], the evaluation of the Healthy Living Pharmacy Programme was launched at the Royal Pharmaceutical Society. Led by a collaboration of all the national pharmacy bodies and supported by the Department of Health and the public health organisations, there are now 508 Healthy Living Pharmacies in England. The results are really impressive. The public ‘strongly’ approved of the pharmacies which have signed up, with over 98% saying they would recommend them. Results have been equally encouraging in Stop Smoking services, with the Healthy Living Pharmacies delivering a significant improvement in the number of quits. The public and patients have also been much more positively engaged in other lifestyle areas where advice and support have been given by pharmacy Health Champions accredited by the Royal Society for Public Health.”

Duncan Selbie, CEO,
Public Health England
**Additions to Part VIIIB Specials Tariff**

In May’s Drug Tariff the following changes to Part VIIIB became effective:

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulations covered by tariff</th>
<th>Minimum volume</th>
<th>Price for minimum volume (£)</th>
<th>Price for each extra ml/g above minimum volume (£)</th>
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</thead>
<tbody>
<tr>
<td>Antacid and Oxetacaine oral suspension</td>
<td>STD, SF, LF, CF, NSF</td>
<td>150ml</td>
<td>257.87</td>
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<td>Colecalciferol 5,000units/5ml oral solution</td>
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<td>Cyclizine 50mg/5ml oral suspension</td>
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<td>192.64</td>
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<td>Dosulepin 25mg/5ml oral solution</td>
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<td>100ml</td>
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<td>Gliclazide 40mg/5ml oral suspension</td>
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<td>Glycopyrronium bromide 2mg/5ml oral suspension</td>
<td>STD, SF, LF, NSF</td>
<td>100ml</td>
<td>197.59</td>
<td>0.15</td>
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</tbody>
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**Deletions to Part VIIIB Specials Tariff**

- Clobazam 10mg/5ml oral suspension (STD, SF, LF, CF, NSF) – now in Part VIIA
- Clobazam 5mg/5ml oral suspension (STD, SF, LF, CF, NSF) – now in Part VIIA

**New endorsement quick reference guide published**


The guide is an alphabetical list of all prescription endorsements recognised by NHS Prescription Services explaining how and when to use them as per Drug Tariff rules.

This new guide is available to download from our publications database: www.psnc.org.uk/publications (categorised under “Endorsing”).
<table>
<thead>
<tr>
<th>Product</th>
<th>Formulations covered by tariff</th>
<th>Minimum volume</th>
<th>Price for minimum volume (£)</th>
<th>Price for each extra ml/g above minimum volume (£)</th>
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<tbody>
<tr>
<td>Hydrocortisone 10mg/5ml oral suspension</td>
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<td>Hyoscine hydrobromide 500micrograms/5ml oral suspension</td>
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<td>Lansoprazole 30mg/5ml oral suspension</td>
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<td>193.54</td>
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<td>Magnesium glycerophosphate (magnesium 97.2mg/5ml (4mmol/5ml)) oral suspension</td>
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<td>100ml</td>
<td>173.96</td>
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<td>Methotrexate 10mg/5ml oral solution</td>
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<td>Methotrexate 10mg/5ml oral solution</td>
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<td>Metoprolol 12.5mg/5ml oral solution</td>
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<td>Naproxen 200mg/5ml oral solution</td>
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<td>Quetiapine 25mg/5ml oral suspension</td>
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<td>Sodium chloride 1.5g/5ml (5.13mmol /ml) oral solution</td>
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<td>Tranexamic acid 500mg/5ml oral suspension</td>
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<td>Venlafaxine 37.5mg/5ml oral suspension</td>
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<td>100ml</td>
<td>164.45</td>
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</table>
Ask PSNC – your frequently asked questions

The PSNC Information Team can provide support on a broad range of topics including whether an item is allowed on an NHS prescription and how much reimbursement to expect for supplying an item. Frequently asked questions include:

1. I have received a prescription, which contains a code, but I don’t know if it is the individual prescriber’s code. Do I need to check that it is the correct code?
No. Pharmacy contractors are only expected to ensure that a code is present and sometimes, in the case of hospital prescriptions, that code may be related to a hospital unit rather than an individual prescriber. NHS BSA staff will check during the recharging process that the code is correct.

As the contractor is not expected to perform any extra work by attempting to validate codes, prescriptions will not be returned to the pharmacy if a code is later identified as being incorrect. These prescriptions will still be paid as normal within the usual timeframes. However, if a contractor suspects the prescription is not a genuine order for the person named on the prescription (e.g. they believe it has been stolen or forged), they should continue to refuse to dispense for that reason.

2. I have received a dental prescription which does not contain a prescriber code, do I need to contact the prescriber to find it out?
No. NHS BSA has confirmed that dental prescriptions do not have prescriber codes and therefore pharmacy contractors can dispense and submit these prescriptions without needing to identify or endorse a prescriber code.

Look out for more frequently asked questions next month…

If you would like more information on whether a particular product is allowed on an NHS prescription, the PSNC Information Team will be happy to help (0844 381 4180 or 0203 1220 810 or e-mail info@psnc.org.uk).

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Do you know...

Spotlight on dispensing Colecalciferol 20,000unit capsules

Processing of prescriptions by NHS Prescription Services (NHS RxS) depends on which version of this vitamin supplement is dispensed. This guidance will help you to identify the type of product sourced and the appropriate dispensing endorsements:

1. Is the purchased product an import?
   - No
   - Yes

2. Is the product a special? i.e. did it come with a Certificate of Analysis or Conformity (COA/COC)?
   - No

Endorse: (see example on the right)
- Quantity dispensed/pack size used
- Invoice price per pack (minus discount or rebates)
- Supplier’s MHRA importer or specials licence number
- Batch number of unlicensed item
- SP (for costs incurred in obtaining the item)

Endorse as per non-Part VIII A product rules (see example on the right).

Any out of pocket expenses incurred can be claimed using the endorsement “OOP” or “XP”, the name of the charge, and the total amount claimed. If necessary, broken bulk can also be claimed.

This guidance is only applicable to colecalciferol solid dose preparations and should not be used for any other specials prescriptions.
The Preface of the Drug Tariff can (and should) be used to identify products which are entering or being removed from the Tariff. Below is a quick summary of the changes due to take place from 1st June 2013. Please note that not every change due to take place can be known in advance.

**Part VIII A changes**

**Category C additions:**
- Colecalciferol 800 unit / Calcium carbonate 1.25g tablets (30) – Kalcipos-D
- Lisdexamfetamine 70mg capsules (28) – Elvanse

**Category A additions:**
- Nitrofurantoin 50mg tablets (28)

**Amendments:**
- Losartan 100mg / Hydrochlorothiazide 12.5mg tablets (28) – Cozaar-Comp is changing to Category A

**Deletions:**
- Nitrofurantoin 50mg tablets (100)
- Povidone K25 5% eye drops 0.4ml unit dose preservative free (20) – Oculotect

**Part IX changes**

**Deletions:**
- DRESSINGS – Absorbent, Perforated Plastic Film Faced, Dressing – Release (all sizes)
- EMOLLIENT AND BARRIER PREPARATIONS – ZeroAQS Cream (100g pack size only)
- STOMA APPLIANCES – Belts – Hi-Line Ltd – Ladies Ostomy belt including hole over stoma optional detachable suspenders
- CHEMICAL REAGENTS – Detection Strips, urine for Glycosuria – Diabur Test 5000

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**Partners in the PSNC Community Pharmacy Development Programme**

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