imPACT

Prescription Pricing Authority Newsletter

Prescription Certificates

Pre-payment, Medical and Maternity Exemption Certificates

In the June 2002 edition of imPACT we explained that responsibility for issuing prescription pre-payment (PPC) medical (Medex) and maternity (Matex) exemption certificates for England will transfer to the Prescription Pricing Authority (PPA) from 1 October 2002. **For further information on this subject please turn to page 3.**

Publication of our Annual Report

At the end of September, we will be publishing our Annual Report for 2001-02. It will be distributed widely amongst primary care organisations and across the NHS. It will also be available for download from our website at www.ppa.org.uk

The past twelve months have contained some major events for us, ranging from the recovery from Category D to the implementation of the ETP pilots. As part of the management report within the Annual Report, we will be highlighting how these initiatives are proceeding and the effect they are having upon our core services and on our performance. We have also seen some significant developments in prescribing volumes and budgets across the country. We are producing a separate commentary on the factors that are driving the increases in volume that we have experienced during 2001-02 and these are analysed and tabulated in our Annual Report and, in more depth, on our website.

In a departure from our practice in the past, we are publishing summary financial statements for both our administrative and pharmaceutical accounts. This allows us greater flexibility to highlight the key information that is of interest to prescribers and dispensing contractors. The full statement of accounts will be published at the end of September alongside the Annual Report and will be available through the website or upon request.

The Annual Report will be available from 30 September. If you would like to register an interest in receiving a copy please email us at impact@ppa.nhs.uk with your name and address, or check out our web or NHSnet sites.

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NHS

Prescription Pricing Authority

Implementing New Initiatives

Shifting the Balance of Power and Pharmacy in the Future

There are several new NHS initiatives taking place this year which will effect the PPA and its systems and services.

Shifting the Balance of Power

In the previous edition of imPACT it was explained that as a result of the re-organisation of Primary Care Trusts and Health Authorities under the Shifting the Balance of Power initiative, we are to start using the non-structured "F" code in all our correspondence and communications with contractors. All pharmacists and appliance contractors will be notified of their new code prior to October 2002 and this code should be used in all communication with us from 1 November 2002 onwards. We will send out FP34 invoices showing the new codes during October for use when submitting October 2002 dispensed prescriptions.

Each month we are notified by each Health Authority of all local payments and deductions due to contractors that month eg Rota payments, and Essential Small Pharmacy payments. These payments, or deductions, are then processed by us and included in that month's contractor payment as shown on the monthly payment schedule.

From October 2002 these local payments will be the responsibility of Primary Care Trusts, an increase of over 300% in users of this system. Therefore, in order to continue to provide fast and efficient processing of these payments, we are updating this service and PCTs will be provided with a new secure NHSnet web-based system for supplying this information to us.

Pharmacy in the Future

October 2002 is also the month when a number of other changes are happening to our systems as a result of the Pharmacy in the Future initiatives. These changes will only affect those contractors participating in these schemes.

The schemes are:

Repeat Dispensing Pathfinder sites.

Local Pharmaceutical Service pilots.

Out of Hours Care Providers (Non-FP10).

Further information on these initiatives can be found on our web site.

"Let us have Electronic Prescribing Information for Outpatients"

A pilot, with two hospital trusts, began in April of this year to allow the trusts to receive electronic information about the cost of drugs prescribed on FP10(HP)s and dispensed in the community. The PPA has developed hospital ePACT.net, an electronic analysis tool, to freely provide this information.

All prescriptions dispensed in the community are processed by us including FP10(HP)s. Many of those received contain unclear organisational details. Consequently a significant manual effort is then applied to allocate them correctly. This results in paper information taking four to five months to reach the prescribers. As the information is paper-based, it does not readily lend itself to being manipulated to provide trends, comparisons, accumulations or other management information.

The pilot sites allocated new codes to each of the specialities within their Trust. Old prescription pads were gathered and destroyed, new ones were issued with the new codes. We are in discussion with the Department of Health to determine how pre-printed FP10(HP)s can be automatically produced to relieve Trusts of the hand-stamping task. The allocation of the codes at speciality level has given sufficient granularity to provide meaningful information (to be sliced, diced, accumulated etc) without adding an unbearable overhead of managing the increased number of different prescription pads.

So far, electronic information has been provided to the Trusts for four months through Hospital ePACT.net and has been greeted with much enthusiasm. Not only is the information delivered three months earlier, but it can be analysed by date, by speciality and by drug (based on BNF classification), producing both reports and graphs for financial and clinical benefits.

For further information please look at our website www.ppa.org.uk

Prescription Certificates Cont.

Pre-payment, Medical and Maternity Exemption Certificates

From 1 October 2002 we intend to introduce a number of changes to the way the above processes will be administered.

Applying for a PPC

The Pre-payment Certificate (PPC) application form (FP95) has been re-designed in order to improve the effectiveness and efficiency of completion and subsequent processing. The double sided A4 document contains all of the relevant guidance on one side and a straight forward area for completion by the patients on the other side.

The PPC application form provides a new opportunity for patients to purchase a certificate using a debit or credit card in addition to the use of cheques or postal orders. We will ensure that initial stocks of the new application forms, plus the appropriate guidance for use, are distributed during September. Existing application forms should be withdrawn from 30 September 2002. We have set up a PO Box for the receipt of postal applications.

There are arrangements currently in place in a number of areas for pharmacies to sell PPCs. These pharmacies are being invited to continue doing so on behalf of the PPA for a temporary period. Letters have been sent to each of these pharmacies explaining how this will be administered. We have no plans to increase the number of pharmacies who sell PPCs before April 2003.

New Telesales Facility

We intend to introduce a new telephone Advice/Order Line. This will be operational from 1 October 2002 and patients will be able to buy their PPC via this service using either a debit or credit card. The local call rate number for this service will be 0845 850 0030.

There will also be a recorded message facility on this number to inform patients of the current cost of 4 monthly and 12 monthly certificates. Patients may also seek advice regarding their eligibility to qualify for medical (Medex) or maternity (Matex) exemption.

Patient Certificates

Another change that we intend to introduce is a move away from the paper exemption certificates that are currently in use. We will issue new credit card style plastic certificates for applications made after 1 October 2002. The same style card will be used for Pre-payment, Medex and Matex. An example of the card layout can be seen in the picture below.

The certificates in use as a result of applications made before 1 October 2002 will still be valid for use until the expiry date shown on the certificate.

Patient Communication

It is appreciated that wall space, particularly in pharmacies is limited; however posters explaining how to apply for exemption certificates will be issued to pharmacies and doctors' surgeries in mid September 2002. It is hoped that you will be able to help us to help the patients by displaying the poster.

Further information about the launch of the service will be provided on our web site www.ppa.org.uk.

Compliance Unit Transfer

In December 1998 the Department of Health published its strategy to tackle fraud and corruption across the NHS "Countering Fraud in the NHS". A key element of this strategy is the adoption of a comprehensive, integrated and professional approach to the problem of fraud in the NHS. As part of the process of achieving a comprehensive and integrated approach it has been decided that the responsibility for the Compliance Unit, the employment of its staff, as well as those within the Pharmaceutical Fraud Team, will pass to a newly created Special Health Authority, that will be responsible for tackling fraud and corruption across the NHS. This transfer will take place from January 2003.

The Compliance Unit is currently responsible for the verification of patient claims for exemption from prescription charges, the management of the penalty charge regime, inquiries into irregularities on claims from pharmaceutical contractors and the recovery of debt from patients and contractors.

The new arrangements will build on the groundbreaking work of the Unit in tackling patient and contractor fraud and irregularities since its establishment in April 1996. From transfer, imPACT will no longer carry information about the work of the Compliance Unit. Any publicity arrangements will be dealt with by the new agency.

PACT Centre Pages - Cardiovascular Prescri

The PACT Centre Pages report on Cardiovascular Prescribing, issued to General Practitioners in May 2002, is reproduced here for readers with an interest in patterns and trends in prescribing.

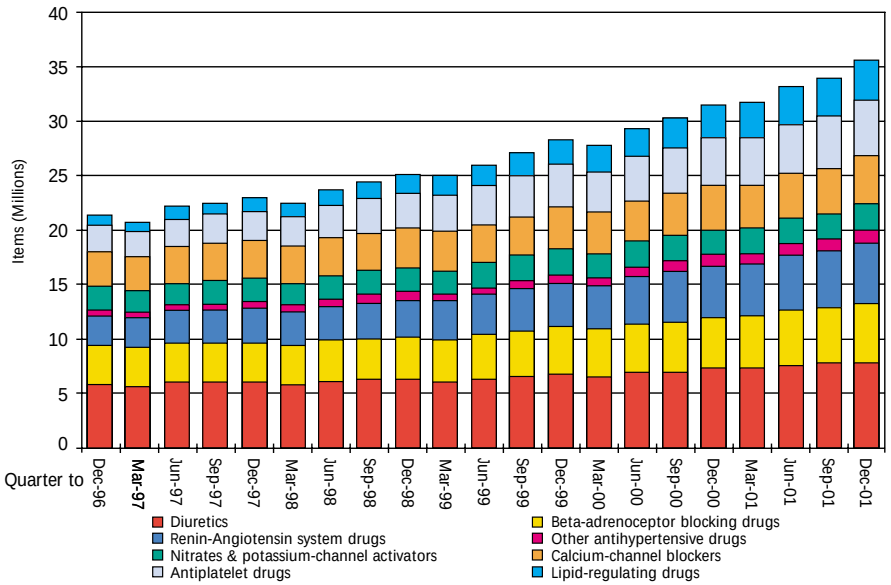
This edition of the PACT Centre Pages focuses on the first two chapters of the National Service Framework for Coronary Heart Disease (NSF for CHD): Reducing Heart Disease in the Population and Preventing CHD in High Risk Patients. It discusses changes in prescribing patterns since the introduction of the NSF and identifies where new evidence from clinical trials may influence future prescribing. Over the last five years prescriptions for the most commonly used cardiovascular drug groups have increased with a corresponding rise in cost (charts 1 and 2). Implementation of the NSF has accelerated growth for drugs used to prevent CHD in the last two years. These increases, particularly for lipid regulating drugs, drugs affecting the renin angiotensin system and calcium channel blockers, are major factors in the growth of the national drugs bill.

Chapter 1 of the NSF is about preventing CHD at the population level by reducing exposure to unnecessary risks. It identifies 4 key interventions: reducing smoking, promoting healthy eating, promoting physical activity and reducing overweight and obesity. Evidence from observational studies supports these interventions[1] but unanswered questions remain about the types of exercise and diet that are of most benefit. Standard 2 of the NSF emphasises reducing the prevalence of smoking. Every health authority had established a smoking cessation service by 2000/01. From April to September 2001, 104,800 people set a quit date through these services. At the 4-week follow-up 51% of those setting a quit date had successfully quit. Prescribing of nicotine replacement therapy (NRT) has increased markedly since April 2001 when all forms of NRT became available on FP10 prescription. In the quarter to December 2001, there were 240,000 items for NRT costing £5.2 million. Total use of NRT funded by the NHS will be higher because NRT is available through other routes such as voucher schemes. Due to concerns about its adverse effects, prescribing of amfebutamone/bupropion has declined from a peak of 146,000 items in the quarter to March 2001 to under 37,000 items in quarter to December 2001.

Chapter 2 of the NSF specifies two main priorities:

1. To identify people with clinical evidence of CHD, ischaemic stroke, transient ischaemic attack or peripheral vascular disease and offer them comprehensive advice and appropriate treatment to reduce their risks.
2. To identify people without diagnosed CHD or other occlusive arterial disease but whose risk of CHD events is greater than 30% over 10 years.

Trends in Prescribing of Cardiovascular Drugs (Chart 1)



There are a variety of tools for risk assessment. The Joint British Societies Coronary Risk Prediction Chart (available in the BNF) is easy to use and provides a good balance of accuracy. Whichever tool is chosen, they all have limitations in some patient groups[2].

Information about modifiable risk factors (smoking, physical activity, diet, alcohol consumption, weight and diabetes) should be provided to people identified under priorities 1 and 2. Drug treatment is targeted at the individual's risk factors (e.g. statins for hyperlipidaemia) and pre-existing conditions (e.g. beta blockers for people who have had a myocardial infarction).

Lipid regulating drugs

Statins and dietary advice to lower cholesterol below 5.0 mmol/l or to reduce total serum cholesterol by 20-25%, whichever would result in the lowest level should be offered to people at high risk of CHD. Equivalent figures for LDL cholesterol are to below 3 mmol/l or by 30%. Prescribing of statins has increased by nearly 5-fold in the last 5 years to 3.5 million items in the quarter to December 2001 at a cost of £119.6 million. Simvastatin is the most frequently prescribed statin followed by atorvastatin (1.5 million and 1.3 million items quarter to December 2001 respectively). Preliminary data from the Heart Protection Study (not yet published) suggest that simvastatin reduces major vascular events in women, the elderly and people with average or below average cholesterol levels[3]. However the priorities for statin use set out in the NSF are unlikely to change as a result of this trial.

Antihypertensive drugs

Prescribing of antihypertensive drugs continues to increase. In the quarter to December 2001 there were 7.8 million items for diuretics, 5.4 million items for beta blockers and 4.4 million items for calcium channel blockers. This represents increases of 35%, 48% and 34% over the last 5 years respectively. In the same period the number of items for drugs affecting the renin angiotensin system doubled to 5.7 million per quarter. These drug groups all have indications other than hypertension therefore some of the increased prescribing will be for other conditions. The highest costs are for drugs affecting the renin angiotensin system (£88.9 million quarter to December 2001) and calcium channel blockers (£71.5 million). Diuretics (£15.8 million) and beta blockers (£21.7 million) cost a lot less.

Use of thiazide diuretics has almost doubled in the last 5 years to 3.8 million items in the quarter to December 2001. However the cost of thiazide diuretics has increased over 4-fold to £5.3 million. 93% of thiazide diuretic items are for bendrofluazide (77% of cost). Atenolol is the most commonly prescribed beta blocker (3.5 million items, £5.3 million quarter to December 2001). Nearly as much is spent on bisoprolol (£4.8 million) but there are a lot fewer items than for atenolol (359,000). ACE inhibitors account for 82% of all items for renin angiotensin system drugs (4.6 million items quarter to December 2001) and 70% of costs (£61.8 million). The most frequently prescribed ACE inhibitors are lisinopril (1.5 million items, £21.6 million) and ramipril (1.1 million items, £15.9 million). Losartan is the most frequently prescribed angiotensin II receptor antagonist (369,000 items at £11.3 million quarter to December 2001).

There is no clear evidence that any drug prescribed solely for hypertension (i.e. excluding people with other indications such as heart failure, stroke or myocardial infarction) consistently produces better cardiovascular outcomes over alternative drugs. Combinations of two or more drugs are often required to maintain blood pressure below 140/85 mmHg. Co-morbidities and contraindications will influence choice of initial therapy, however a thiazide diuretic or a beta blocker is cost-effective in many patients. There is now evidence that lowering blood pressure is beneficial in patients with previous stroke or TIA, however it is not clear

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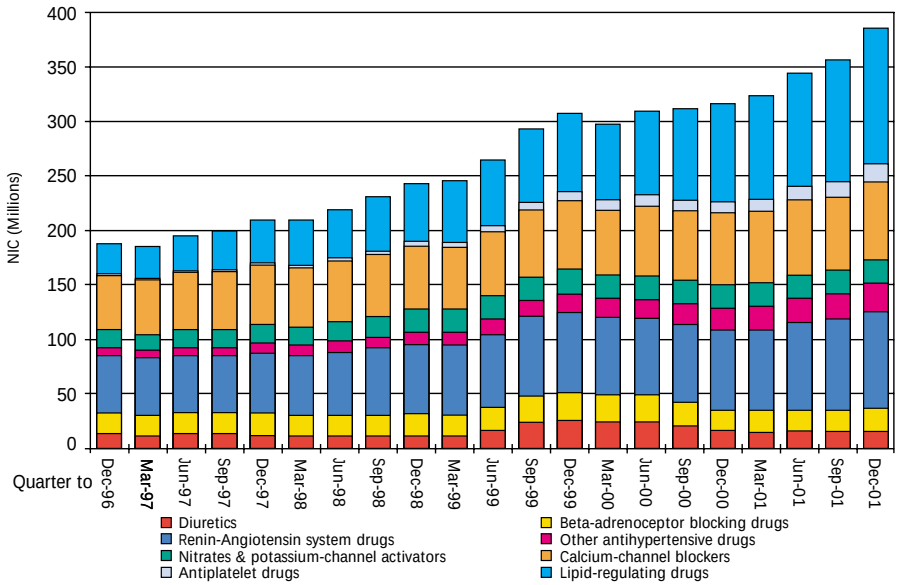
Trends in Spending on Cardiovascular Drugs (Chart 2)



whether any particular drug class offers greater benefits[4]. For patients who have had a myocardial infarction the NSF recommends a beta blocker (whether or not hypertension is also present). For people who have left ventricular dysfunction, an ACE inhibitor is recommended.

The recent LIFE study showed that in a selected group of patients with hypertension and left ventricular hypertrophy, patients on losartan experienced the primary composite end point of cardiovascular death, myocardial infarction and stroke significantly less often than patients on atenolol[5]. The number needed to treat (NNT) for this end point is 56. Exclusions from LIFE included recent myocardial infarction or stroke; heart failure; and angina requiring treatment with beta blockers or calcium channel blockers. The results of this study are therefore not directly applicable to many of the high priority patients identified for treatment in the NSF.

Antiplatelet drugs

Among patients at high risk of occlusive vascular events antiplatelet therapy reduces the relative risk of any serious vascular event by about one quarter[6]. The NSF only recommends low dose aspirin for patients with diagnosed CHD or other occlusive arterial disease. Whether the benefits of aspirin outweigh its risks in people without symptoms of cardiovascular disease is still uncertain[1]. Prescribing of antiplatelet drugs has doubled in the last 5 years reaching 5.1 million items for the quarter to December 2001. At the same time their cost has increased 10-fold to £15.9 million. Aspirin is by far the most frequently prescribed antiplatelet drug (91% of items and 25% of cost, quarter to December 2001). Clopidogrel is used much less frequently (4% of items) but it accounts for 57% of antiplatelet cost.

There is a 3-fold variation in total spending (NIC/1,000 PUs) on antiplatelet drugs across health authorities, whilst spending on clopidogrel shows a 5-fold variation. Health authorities spending the most on antiplatelet drugs are nearly all in the North and have high rates of CHD. Aspirin is the most cost effective antiplatelet drug to reduce the risk of vascular events in high risk patients. Clopidogrel appears to be a safe and effective alternative but there is substantial uncertainty about the size of any additional benefit compared to aspirin[7]. In patients with acute coronary syndrome without ST-segment elevation, clopidogrel plus aspirin for up to 12 months was more effective in preventing a combined outcome of cardiovascular death, non-fatal myocardial infarction and stroke than aspirin alone (NNT 48)[8]. However evidence of benefit from using clopidogrel plus aspirin in patients with stable angina is lacking and because of the risk of bleeding it should not be used in these people (who are at lower risk of a cardiovascular event).

References

1. Murphy M et al. Cardiovascular disorders Primary prevention. Clin Evid 2001; 6: 82-113
2. National Prescribing Centre. Assessing cardiovascular risk (part 2). MeReC Bulletin 2000; 11: 29-32
3. www.ctsu.ox.ac.uk/~hps/
4. National Prescribing Centre. Secondary prevention of stroke: what does the PROGRESS trial add? MeReC Extra 2001; issue3
5. Dahlof B et al. Cardiovascular morbidity and mortality in the Losartan Intervention for Endpoint reduction in hypertension study (LIFE): a randomised trial against atenolol. Lancet 2002; 359: 995-1003
6. Antithrombotic Triallists' Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. BMJ 2002; 324: 71-86
7. C. Sudlow. Cardiovascular disorders Secondary prevention of ischaemic cardiac events. Clin Evid 2001; 6: 117-119
8. The Clopidogrel in Unstable Angina to Prevent Recurrent Events Trial Investigators. Effects of clopidogrel in addition to aspirin in patients with acute coronary syndromes without ST-segment elevation. N Engl J Med 2001; 345: 494-502

Summary

- Key interventions to prevent CHD at the population level are: reducing smoking; promoting healthy eating; promoting physical activity and reducing overweight and obesity.
- The highest priorities for statin use are people with established CHD and people whose risk of a CHD event is greater than 30% over 10 years.
- There is no clear evidence that any class of antihypertensive drug consistently produce better cardiovascular outcomes.
- Lowering blood pressure is beneficial in patients with previous stroke or TIA.
- Aspirin is the most cost effective antiplatelet agent to reduce the risk of vascular events in high risk patients.

The Future of IT in the NHS

You will no doubt remember that in the April 2002 the NHS received some good news with respect to funding. In the budget, commitment was made to an increased investment in the NHS to fund a "catch-up" period leading to health spending of 9.4% of GDP by 2008. This, together with the Wanless report on securing the future of the health service and delivering the NHS Plan, has prompted the Department of Health (DH) to re-evaluate its IT strategy.

In June 2002 the DH published its updated National Strategic Programme entitled "Delivering 21st Century IT Support for the NHS". (see **www.doh.gov.uk/ipu/whatnew/deliveringit/index.htm**)

In this document it states "The vision for information and IT is to connect delivery of the NHS Plan with the capabilities of modern information technologies."

At the very heart of the strategic programme for IT there are four major national deliverables. It is intended that the NHS will firstly develop the right IT infrastructure to form the robust platform for key applications and then deliver the three remaining critical national services around electronic records with clinical tools, electronic prescribing and electronic appointment booking.

The delivery of the vision has been identified in four phases, the first two of which have what is described as "Firm Scope". Phases zero and one cover the period from April 2002 to December 2005 and include within the application services the delivery of a "National Prescription Service" that will be 50% implemented. Phases two and three of the programme will be firmly defined during the

calendar years 2003 and 2006 respectively. It is tentatively identified that the National Prescription Service will be 100% complete by December 2007.

In developing a National Prescription Service the Electronic Transmission of Prescriptions project has created partnerships from the private sector who have worked with us to deliver the three pilots.

All three pilots (Pharmacy2U, SchlumbergerSema and TransScript) are now either in beta test or in a position to move into beta test stage, transmitting live messages from GPs and Pharmacists. Messages submitted by pharmacies for payment are being processed through the PPA systems and payments are being made on a monthly basis, combining paper and electronic submissions.

The pilots are continuing to put more pharmacies through acceptance testing after which, they will progress to live transmission and ultimately increase the volumes of electronic prescription messages. For further information on the pilots please visit the PPA sites (**www.ppa.nhs.uk, www.ppa.org.uk**).

The ETP work stream within the National IT Programme is currently being established and a key objective will be the development of the business case for national rollout. This will consider the options for a preferred national model, taking into account the work of the pilots and the need for integration with the objectives of the overall programme. More details about the work stream and its project structure will be available soon from the DH web site.

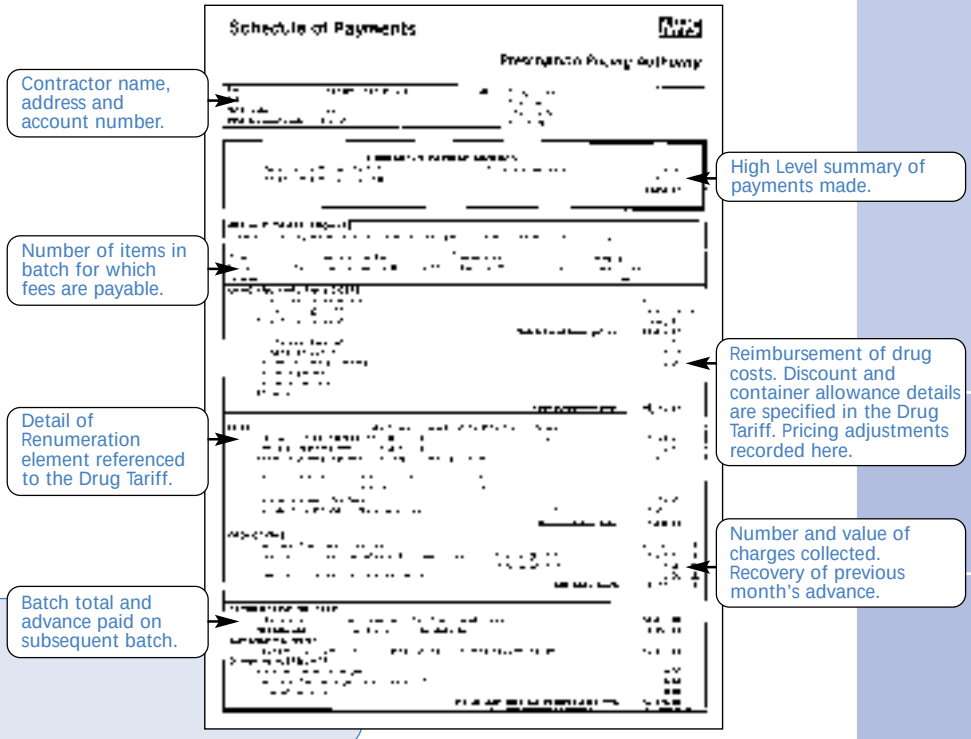
The Payment Schedule Explained

We produce a payment schedule each month for Pharmacy Contractors, Appliance Contractors and Oxygen Concentrator Suppliers. The format of this schedule varies between the three types of contractors however the basic information is the same, in that it details how the payment has been derived and includes supporting information on the content of the batch which has been processed.

This article considers the Pharmacy Schedule of Payments.

Over 10,000 schedules are produced monthly, with each one containing a minimum of 3 sheets of A4 paper.

The diagrams explain where various sections of information are contained on the schedule:

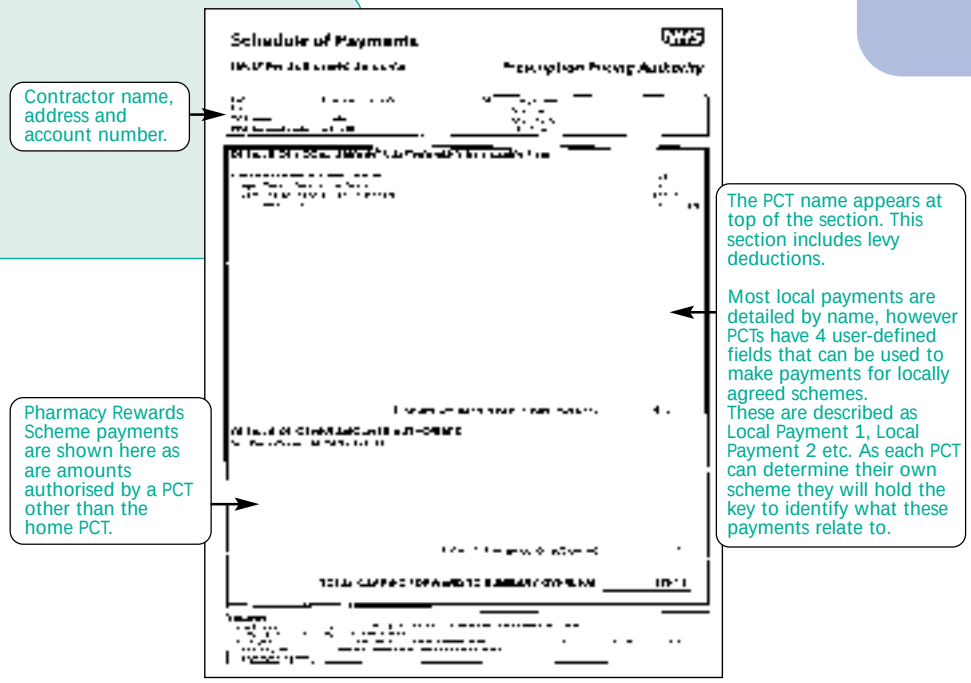


Page 1

This page deals with high level summary information and information regarding prescription processing.

Page 2

Page 2 contains details of payments by health authorities responsible for holding the contracts with the Pharmacy Contractors and other authorised payments. From 1 October these contracts will be transferred to the relevant PCT.



Page 3

This page gives the number of prescriptions and an explanation why prescriptions may have been transferred between the exempt and chargeable group of the batch.

Included on this page is information regarding the temporary concession with forms which bear a computer printed age or date of birth on the front to show under 16 or 60 years or over, these forms have not been transferred, therefore prescription charges are not affected.

Page 4

Pages 4 and onwards (if required) give the total of all items that have a basic price between £100 and £300. The details of all items that have a greater basic price than £300 are also provided, with each item being listed separately.

Future Developments

We are keen to provide contractors with as much information as is practical relating to the payment that they receive. As can be seen from the outlines above the schedule already contains a lot of detail. With the advent of ETP and reengineering of our systems in the medium term, we hope to redesign the schedule and to transmit it electronically to those contractors.

Additional copies of payment schedules can be re-produced at a charge (currently up to £10 each).

Open Meeting

Our October meeting of the Prescription Pricing Authority will, for the first time, include a public session to receive the Annual Report for 2001-02. In previous years, we have held a dedicated open meeting to do this. The meeting will be held on 10 October. For further information on venue and time please contact carol.hailes@ppa.nhs.uk

PPA Conference

We will be following the Authority meeting up with our first one-day conference for users of our services in February 2003. We are planning to centre the event on a number of themes. These will cover ETP, the development of the Primary Care Drug Dictionary, issues affecting simplification of the rules sets, and providing information to support the extension of prescribing responsibilities. We are hoping that holding the event in February 2003 will enable us to incorporate elements of the evaluation of the ETP pilots and to discuss how the PPA is moving forward to the full ETP rollout.

We will be publishing more details of the February event later in the year.

To register your interest or if you have any suggestions for topics we might cover, please email impact@ppa.nhs.uk

Hints and Tips

Temporary Concession

Please note - The Department of Health has agreed to extend the temporary concession for age-related prescriptions until further notice. This means that prescription forms which have a computer-generated date of birth indicating that the patient is exempt from prescription charges will be reimbursed on the basis that no charge has been collected, even if the reverse of the form is not signed. You are reminded, however, that checking unsigned prescriptions for computer-generated dates of birth does require administrative intervention at the PPA therefore we would ask you to do all that you can to ensure that the declarations on the reverse of the form are correctly completed.

Sticky Prescriptions

Please note - Some of our Processing Divisions are experiencing problems within their systems by what can only be described as "sticky prescriptions"! Apparently, a number of pharmacists are putting sticky labels on their prescriptions at some point in the dispensing process and then removing the labels prior to despatching the prescriptions to the PPA. A sticky residue is left behind which causes problems within the highly sensitive numbering machines used at the beginning of our processes. It would greatly aid us if sticky labels were not used at all, as even those that have been removed can slow down our systems.

Forms FP10 (P)

A reminder - Nurses who have undertaken the extended formulary training will use the Forms FP10 (P) bearing the printed annotation at the top of the main body of the form "EXTENDED FORMULARY NURSE PRESCRIBER" and "PN" at the top of the column to the right. Such nurses are qualified to prescribe the greater range of items as specified in Part XVIIB (ii) of the Drug Tariff.

Zero Discount Lists

Please note - With the agreement of PSNC, a number of products that had been discontinued for more than two years were deleted from the "Zero Discount Lists" from 1 August.

Glucosamine Sulphate

A reminder - A number of brands of Glucosamine Sulphate products were added to Schedule 10 of the National Health Service (General Medical Services) Regulations 1992 from 1 August 2002, thus joining the long-standing entry Health Perception Glucosamine entry (which is listed under "H" in Schedule 10). If you receive a prescription for a Glucosamine product it is advisable to look in Part XVIIIA of the Drug Tariff **under the brand name you may be thinking of supplying** as you may find that reimbursement can no longer be allowed for that brand.

Schedule 10 Deletions

Still on the topic of disallowed products - you will have also seen that two products were deleted from Schedule 10 from 1 August - Cow & Gate Nutriprem 2 and Farley's Premcare. Simultaneously with the deletions of these two products, they were granted approval by the Advisory Committee on Borderline Substances (ACBS) to be prescribed on FP10 and were added to Part XV of the Drug Tariff as being nutritionally suitable for catch-up growth in infants.

Mentor Medical

For information - All Sims Portex products are now marketed under the Mentor Medical banner and Part IX of the Drug Tariff was amended in August to reflect this change, thus any appliance previously found under Sims Portex can now be found alphabetically under Mentor Medical.

Elastic Hosiery

Please note - There is now a new Class 1, Circular Knit made-to-measure entry under Elastic Hosiery in Part IX of the Drug Tariff which means that you are now able to supply such a garment to a patient's individual measurements where the stock size was not previously suitable.