Prescribing Element of the Primary Care Quality Premium

2015-2016
1. Introduction

1.1 The aim of the Prescribing Element of Primary Care Quality Premium is to deliver quality improvements in medicines management at a time of limited resource growth.

1.2 The work areas included in the Medicines Management Work Plan for 2014-2016 are aligned with CCG current priorities and reflected in the PCQP 2014-16. The prescribing element for 2015-16 recognises the influential role of CCG Clinical Leads (for Prescribing) and Practices in driving up prescribing quality, reducing risk of harm to patient’s from medication, minimising waste and reducing unnecessary prescribing expenditure. The prescribing element of the Quality Premium aims to provide resource and support for sustainable improvements to systems and process for medicines management within GP Practices.

2. Principles

2.1 Decisions relating to prescribing and medicines management must always focus on quality of prescribing and the needs of the patient. This is in line with the CCG’s duty to support improvements in primary care. Savings must not be made at the expense of patient care.

2.2 The aim is to raise prescribing and medicines management performance to that of best practice as defined by NICE, NHS England and local prescribing guidance e.g. Pan Mersey APC.

2.3 The programme will facilitate the CCG in its requirements to meet and implement both local and national targets and the Primary Care Quality Premium 2014-16

2.4 An evidence-based and cost-effective approach to prescribing and medicines management should be adopted. Practices who achieve the targets of the programme will be rewarded with payments linked to their list size.

2.5 In relation to the Quality Premium, PMS Plus practices must choose therapeutic areas that are different from those stipulated in their PMS Plus contract such that improvements made in prescribing for the Quality Premium cannot be used to fulfil the terms of their PMS Plus contract.

3. Payment

3.1 The funding for the Prescribing Quality Premium for 2015-16 is £2 per head approximately £323,632, based upon 161,800 patients registered to Knowsley practices as of 1st January 2015.

3.2 Payment will be based on list size. Upon hitting the targets practices will be reimbursed £1.00 per patient based on their list size for the Prescribing Lead Role and £1.00 per patient based on their list size for the two selected areas, preferably one from section 4.2 and one from section 4.3.
3.3 Information on number of patients for each practice will be provided at the beginning of the year for verification with the practice, and this will be updated each quarter. Payment allocation will be split into the four subsections of the programme.

4. The Prescribing Quality Premium for 2015-16 is made up of 3 components:

1. Prescribing Lead Roles and Implementation of a Prescribing Review Practice Plan
2. Medicines Safety (select option (a) or (b))
3. Good Practice Prescribing (select option (a) or (b))

4.1 Practices are expected to, in addition to compulsory sections 1, to select (a) or (b) from both sections 2 and 3. Selections should be conveyed to a member of the Medicines Management Team within four weeks of receiving the prescribing element of the Quality Premium for 2015-16.

4.2 Section 1 - Prescribing Leads Roles and Implementation of a Prescribing Review Practice Plan

4.2.1 The practice must appoint a Prescribing Lead. The Prescribing Lead must be a GP or non-medical prescriber. The Prescribing Lead will:

- Ensure a minimum of two practice based prescribing meetings for all the practice’s prescribers with the involvement of at least one member of the Medicines Management Team. In the event of the nominated Prescribing Lead being unavailable for the meeting, the Prescribing Lead should ensure that a deputy attends in his/her place.
- Provide feedback to other practice clinicians to ensure key messages from the MMT are cascaded to all relevant staff.
- In conjunction with the MMT agree and implement a practice prescribing review plan which is likely to include:
  - Medicines safety work e.g. Review of MRHA Alerts
  - Identification of appropriate switches and patient reviews that increase prescribing cost effectiveness
  - Liaise with their respective practice clinicians and the MMT in facilitating the implementation of these switches and reviews
  - A MMT assessment of the safety of practices repeat prescribing system
- Produce a summary of the actions / outcomes that result from the implementation of the prescribing review plan by 18th March 2016
- Be the point of contact for their practice with regards to consultation on draft Area Prescribing Committee documents, proposed safety initiatives and other draft medicines related documents. They will be required to cascade these
documents to other clinicians within their practice for comment and will feedback these comments on behalf of the practice.

- Be the point of contact and lead for any development work around medicines management within the practice e.g. discussions on implementation of the Prescribing Element of the Quality Premium, feedback on the use of Prescribing Support Software (e.g. ScriptSwitch or Similar)

4.3 Section 2 - Medicines Safety

4.3.1 Choose (a) or (b)

4.3.2 (a) Review of Bisphosphonate Prescribing

4.3.2.1 Bisphosphonates have a well-established place in the treatment of osteoporosis. However, there is evidence and concerns that long term treatment may increase bone fragility by suppressing normal bone remodelling, essential for repair of skeletal micro-damage. The majority of studies of bisphosphonates lasted less than 5 years; however, the results of a few study extensions suggest that patients with bone mineral density (BMD) measured as femoral neck T score greater than -2.5 after 3-5 years of treatment and who did not suffer further fragility fractures, are unlikely to benefit from continued treatment.

4.3.2.2 This section aims to review patients who have been on bisphosphonate treatment for osteoporosis for 5 years or more and instigating a drug holiday where appropriate, as per the flow chart below
4.3.2.3 In patients receiving oral bisphosphonates (alendronate, ibandronate, risedronate and etidronate), treatment is usually given for five years in the first instance. If bone mineral density (BMD) remains the same or has improved from baseline, the post-treatment femoral neck T-score is greater than −2.5 and no fractures have occurred during treatment, it is advisable to discuss a bisphosphonate treatment holiday for two to three years, with reassessment of fracture risk at the end of that time and re-continuation of treatment if indicated.

4.3.2.4 NOTE: this does not apply to patients who continue to take oral steroids, since they continue to have an increased fracture risk. Such patients should be excluded from this review.

4.3.2.5 Patients who had a previous fragility fracture who should continue treatment if T score is below −2.5. Patients on a treatment holiday can be legitimately excluded from the osteoporosis QoF targets.

4.3.2.6 A minimum of 80% of all patients on a bisphosphonate for 5 years or more should have a documented assessment of a need for a bisphosphonate break recorded in their patient record. For the purpose of measuring progress on this piece of work the final determination of improvement will be based on submission of a summary sheet (to be provided by the Medicines Management Team) by 30th October 2015.

Or

4.4. (b) Safer Use of NSAIDs (including Coxibs); the importance of gastroprotection

4.4.1 NSAIDs including Cox IIs (Coxibs) are effective and widely used treatments for pain and inflammation, but can cause serious side effects. The adverse effects include gastrointestinal bleeds, pro-thrombotic events (e.g. heart attack, stroke) and reduced renal blood flow leading to acute kidney injury. This can result in potentially preventable hospital admissions.

4.4.2 This audit will focus on gastrointestinal safety. The audit will probably identify some patients on regular, long-term NSAID therapy without gastro-protection. [NICE guidance requires all patients aged over 45 prescribed long-term NSAIDs and Coxibs to be considered for co-prescribed gastro-protection (e.g. a proton pump inhibitor)]. This is particularly pertinent in patients prescribed other medication with a bleed risk.

4.4.3 A minimum of 80% of all patients currently prescribed an NSAID but not a PPI, should have a documented assessment of the need for PPI prophylaxis recorded in their patient record. For the purpose of measuring progress on this piece of work the final determination of improvement will be based on submission of a summary sheet (to be provided by the Medicines Management Team) by 30th October 2015.
4.4.4 Outlying practices for this therapy area are encouraged to adopt this therapy area as one of their topics for review in 2015-16.

4.5 Section 3. Good Practice Prescribing

4.5.1 Choose (a) or (b)

4.5.2 (a) Hypnotic prescribing review

4.5.2.1 The term “hypnotic” used in the following text includes Z-drugs. National data shows Knowsley CCG has a high level of historical benzodiazepine hypnotic prescribing with the following risks:

- Long term use of benzodiazepine hypnotics (and Z drug) is not licensed – the maximum recommended treatment is 2-4 weeks. Dependence and tolerance can develop within days.
- Long term benzodiazepine hypnotic use (and Z drug) is associated with an increased risk of falls and fractures, road traffic accidents, memory loss, confusion, ataxia, low mood and insomnia.
- Withdrawal syndrome can develop any time up to 3 weeks after stopping treatment and can result in anxiety symptoms, distorted perceptions, and rarely, seizures, and hallucinations. Dose reduction and withdrawal should therefore be done gradually.

4.5.2.2 A minimum of 80% of all patients currently prescribed a hypnotic on repeat prescription should have a documented assessment of a review and assessment for further continuation of the hypnotic at the current dose. For example can the patient be stepped down to a lower dose and then the frequency of use also reduced.

4.5.2.3 Outlying practices for this therapy area are asked to adopt this therapy area as one of their topics for review in 2015-16.

4.5.2.4 For the purpose of measuring progress on this piece of work the final determination of improvement will be based on submission of a summary sheet (to be provided by the Medicines Management Team) by 18th March 2016.

4.5.2.5 For support and information
Benzodiazepine and Z Drug Withdrawal
http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal

Or

4.6 (b) Prescribing review of Co-codamol 30/500mg

4.6.1 Co-codamol 30/500mg tablets and capsules are licensed for the treatment of moderate pain. It has typical opioid side effects, e.g. respiratory depression
and constipation, and psychiatric reactions. It is a widely used analgesia and as well as being addictive it can be abused by some people.

4.6.2 An audit of patient’s prescribed Co-codamol 30/500mg would help to ensure that the prescribing of Co-codamol is safe, appropriate and regularly reviewed, in line with local chronic pain guidelines (Pan Mersey APC Formulary). A review of patients prescribed Co-codamol would assess whether:

1. The patient has had a documented analgesia review in the last 12 months
2. Co-codamol 30/500mg has been prescribed following paracetamol and/or Co-Codamol 10/500mg, or 30/500mg having been tried by a patient at the maximum daily dose
3. Co-codamol (or any other opiate) is not co-prescribed with strong opiates
4. Treatment with Co-codamol is short and intermittent
5. Co-codamol is being used with caution in patients with a history of addiction or dependence

4.6.3 A minimum of 20% of all patients currently prescribed Co-codamol30/500mg (including branded medication) on repeat prescription, should have a documented assessment of a review and assessment for further continuation of Co-codamol 30/500mg at the current dose and monthly quantity. For example, can the patient be stepped down to a lower dose of co-codamol or to paracetamol and then the frequency of use also reduced.

4.6.4 For the purpose of measuring progress on this piece of work the final determination of improvement will be based on submission of a summary sheet (to be provided by the Medicines Management Team) by 18th March 2016.

4.6.5 Outlying practices for this therapy area are asked to adopt this therapy area as one of their topics for review in 2015-16.

5. Potential payment if all sections are achieved

Assessment of achievement will be made by the Medicines Management Team and approved at the Neighbourhub governance meetings.

Payment will be based on list size. Upon hitting the targets practices will be reimbursed £1.00 per patient based on their list size for the Prescribing Lead Role and £1.00 per patient based on their list size for the two selected areas, preferably one from section 4.2 and one from section 4.3.

5.1 Current List size ___________________ £____________________________
(BASED ON CURRENT LIST SIZE)

6. Appeals

6.1 Practices can, at year-end, appeal against their assessed payment.
6.2 With good reason an appeal, in writing, may be submitted to the Head of Quality and Safety making a case to justify their appeal.

6.3 Appeals will be considered by the Primary Care Commissioning Committee and the practice will be informed of the decision and its rationale.