Prescribing Quality and Savings Scheme 2013/14

The 2013/14 Prescribing Quality and Savings Scheme builds on previous years’ schemes and aligns with the National, London and Haringey Quality, Innovation, Productivity and Prevention (QIPP) agenda.

The purpose of the scheme is: To encourage and reward cost-effective and high quality prescribing.

Principles

- Incentives should reward improvements in patient care and efficient use of resources. It is therefore important that the PQSS does not simply reward low cost prescribing, but should include criteria relating to the quality of the prescribing.
- To support financial stability without compromising patient care.
- The scheme should encourage practices to consider both cost and quality, and hence cost-effectiveness of prescribing, and reward practices appropriately.
- The CCG recognises that practices that are already achieving the targets specified in the scheme should be rewarded in the same way as those practices meeting the targets for the first time.
- Practices may want help or support to bring about change. This year there will be an increased availability of the Medicines Management Team (MMT) to provide advice and support for the scheme.
- The scheme will run from 1st April 2013 to 31st March 2014

Due to the large savings in the last 2 years, arising in part from significant generic savings, the payments to practices have been significantly scaled down to stay within the overall savings budget.

For the 2012/13 scheme, practices are predicted to receive an average of £5,900 per practice (range £270-£22,600).

Eligibility to participate in the scheme: The scheme will be available to all practices.

Entry Criteria

To qualify for the scheme practices should come within budget at year end. Adjustments will be made for genuine unforeseen changes (see Appendix 3)

Optional Criteria

The scheme will consist of 7 indicators. For each indicator achieved the practice will be awarded 10% of their total savings. The maximum percentage of savings a practice can be awarded is 70%. In addition to the seven indicators on the scheme practices may chose to work on additional opportunities suggested by their prescribing adviser to maximise their savings. NB: If the level of payments exceeds the available resources (currently £315,000), the level of payments will need to be scaled down proportionately.

Exception reporting

Practices participating in the scheme may exception report if they feel they have clear and auditable reasons. The decision to exception report must be based on clinical judgement. There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the 7 indicators. Recognised changes in clinical practice during the running of the scheme will also be an accepted reason for exception reporting or may trigger a need to review the indicator and/or target. An anonymised exception report should be sent to the practice’s Prescribing adviser along with the auditable reason no later than the stated submission dates.
<table>
<thead>
<tr>
<th><strong>ENTRY CRITERIA</strong></th>
<th><strong>TARGET</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To qualify for the scheme practices should come within budget at year end. Adjustments will be made for genuine unforeseen changes (Appendix 1)</td>
<td>Stay within allocation</td>
</tr>
</tbody>
</table>

**OPTIONS**

<table>
<thead>
<tr>
<th><strong>TARGET</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDICATOR 1: ANTIBIOTIC CHOICE</strong></td>
</tr>
<tr>
<td>Antibiotic Prescribing: Reduce the use of Quinolones and Cephalosporins, a member of staff to complete a National Prescribing Centre e-learning resource on antibiotics, share learning with practice staff and send a record of actions taken to the Medicine Management Team</td>
</tr>
</tbody>
</table>
| **INDICATOR 2: EDUCATIONAL SUPPORT TO SURVEY AND IMPROVE PRESCRIBING IN TYPE 2 DIABETES** | a. Attend an educational event organised by the Medicines Management Team  
  b. Complete a survey and submit by 31 March 2014 |
| a. Attend an educational event organised by the Medicines Management Team  
  b. Survey the use of newer oral antidiabetic agents being used in your practice |  |
| **INDICATOR 3: SCRIPTSWITCH PERFORMANCE** | Actions completed and report submitted by 31 March 2014 |
| • Ensure Scriptswitch is activated on all terminals used for prescribing  
  • Review a 6 month practice report and agree action points  
  • Suggest three areas of improvements e.g. where savings can be made or where recommendations of alternative preparations will result in savings+ |  |
| **INDICATOR 4: THERE WILL BE AN INCREASED PRESENCE OF PRESCRIBING ADVISERS WORKING IN GP PRACTICES** | Evidence that GPs have worked collaboratively with prescribing advisers |
| Practices to work with prescribing advisers on suggested projects, over a defined period with agreed outcomes. Areas covered will be around the “Organisational Domain” medicines management aspect of 12/13 QoF |  |
| **INDICATOR 5:** | Review high dose ICS items as % of all ICS items  
  Submit audit by 31/3/2014 |
| • Review the use of high dose Inhaled corticosteroids in asthma and stepped down as appropriate  
  • Ensure Patients on steroids (especially high doses) are being offered and counselled on using a spacer and this is recorded in notes and routinely monitored  
  • Use cost effective products when possible (Fostair) |  |
| **INDICATOR 6:** | a. £125 per 1000 Astro-PU per Quarter  
  b. ≥ 60% Beclometasone & budesonide items expressed as a percentage of all intranasal steroids |
| a. Reduce prescribing of 9 “Grey List” medicines for which cost-effective alternatives exist or which have limited clinical value  
  i. Non Sumatriptan triptans  
  ii. Venlafaxine MR  
  iii. Quetiapine MR  
  iv. Prednisolone EC  
  v. Quantities of phosphodiesterase type-5 inhibitors (excl sildenafil) for erectile dysfunction  
  vi. Bath emollients  
  vii. Doxazosin MR  
  viii. Glucosamine  
  ix. Fexofenadine  
  b. Compliance with recommended 1st Beclomethasone, 2nd Budesonide and 3rd line fluticasone choice of intranasal steroid |  |
| **INDICATOR 7:** | ≥ 26% Oxybutinin and tolterodine immediate release items as a percentage of all urinary frequency drugs |
| Oxybutinin and tolterodine immediate release as 1st line choice. Use oxybutinin and tolterodine IR as 1st line choice for urinary frequency. |  |
**Indicator 1: Antibiotic choice**
Antibiotic Prescribing: Reduce the use of Quinolones and Cephalosporins, a member of staff to complete a selected NPC e-learning repository on antibiotics and share learning with practice staff

**Target:**
Quinolones and Cephalosporins items Equal to or less than 5.5% of all antibiotics items during the period Nov to Dec 2013

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**Rationale for Indicator**
The Chief Medical Officer (CMO) Annual report Volume 2 (2011) released in March 2013 focuses on ‘Infections and the rise of antimicrobial resistance’. A ticking time bomb is how the report summarises the impact of antimicrobial resistance. The report highlights that, while a new infectious disease has been discovered nearly every year over the past 30 years, there have been very few new antibiotics developed leaving our armoury nearly empty as diseases evolve and become resistant to existing drugs.

In addition to encouraging the development of new drugs, the report highlights that looking after the current supply of antibiotics is equally important. This means using better hygiene measures to prevent infections, prescribing fewer antibiotics and making sure they are only prescribed when needed.

**Key points**

- The Health Protection Agency (HPA) recommends using simple generic antibiotics where possible. Avoiding broad spectrum antibiotics (e.g. co-amoxiclav, quinolones and cephalosporins) when narrow spectrum antibiotics remain effective, can reduce the increased risk of *Clostridium difficile*, MRSA and resistant UTIs. Although there has been a recent decrease in cases there still remains a risk to the public. Responsible prescribing will reduce this risk.

- Broad-spectrum antibiotics need to be reserved for treating resistant disease, and should generally be used only when narrow-spectrum and less expensive antibiotics are ineffective.

- The prescribing of quinolones (for example, ciprofloxacin) in general practice is a particular cause for concern. They are only recommended first-line by the HPA and in our locally adapted guidelines in limited situations (for example, acute pyelonephritis or acute prostatitis). Resistance to quinolones is increasing at a considerable rate (for example, quinolone-resistant *Neisseria gonorrhoeae*).

- Prevention of the development of resistance is important. Antibiotics should only be prescribed when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats. Consider a no, or delayed antibiotic strategy for acute self-limiting upper respiratory tract infections.

- To assist prescribers with achieving this indicator one member of the practice will be expected to access, read and reflect on the NPC e-learning resource on antibiotic prescribing and share their learning with the rest of the practice. Available from:
  - http://www.npc.nhs.uk/qipp/resources/antibiotics_prescribing_keyslides.ppt
  - http://www.npc.nhs.uk/qipp/resources/antibiotics_prescribing_qipp_notes.doc

**What you need to do to achieve this indicator**

a. Practices should send in minutes of a practice meeting where the learning was shared with the rest of the practice staff and a resulting action plan following discussion of the slides and notes.
For more information and Patient Information Leaflet (see ref 3)
b. Only prescribe Quinolones and Cephalosporins in line with local guidelines
% cephalosporins & quinolones items of all antibiotics items Oct, Nov and Dec 2012 target less than 5.5%

References
1. Annual Report of the Chief Medical officer Vol Two, 2011 Infections and the rise of antimicrobial resistance
   http://www.google.co.uk/search?hl=en&q=Annual+report+Volume+2+(2011)+released+in+March+2013&meta=
4. Management of Infections Guidelines in Primary Care 2011-2013
   http://nww.haringey.nhs.uk/MedicinesOptimisation/Prescribing%20Guidelines/Management%20of%20Infections%20Guide.pdf
**Indicator 2: Educational support and survey to improve prescribing in type 2 Diabetes**

a. Member of practice to attend an educational event organised by the Medicines Management Team  
b. Survey the use of newer oral antidiabetic agents being used in your practice

**Target:**

a. Member of practice to attend the training event  
b. Survey completed by 31 March 2014

**Background**

Over the last decade there has been a significant rise in more intensive new treatments and analogue insulins for type 2 diabetes. These therapies are often expensive with limited evidence of additional benefit and accumulating evidence of harm.

The total diabetes drug bill in England was £725 million in 2010/11 comprising the largest cost section in the BNF. Analogue insulins are the largest single cost - £269 million out of £307 million spent on insulins of all kinds. New agents – glitazones and the more recent rapid increases in glutides, gliptins, and glinides are in second place in terms of cost, so that combined, analogue insulin and these new agents now account for 60% of the national diabetes drugs bill.

**Evidence of benefit**

New drugs for glycaemic control in diabetes should reduce cardiovascular events, increase life expectancy and improve quality of life. Gale and Yudkin in the UK have concluded that there is currently no evidence that intensive therapy with these newer agents achieves these goals. [http://www.slideshare.net/ekader47/edwin-galecost-effective-diabetes-treatment-12146623](http://www.slideshare.net/ekader47/edwin-galecost-effective-diabetes-treatment-12146623).

Type 2 (T2) Diabetes reduces these three aspects of life largely through its impact on cardiovascular disease – micro and macrovascular. At any level of risk T2 diabetes approximately doubles CVD risk. But the evidence that increased levels of glycaemia are causally related to CVD outcomes such as heart attack or stroke, is much weaker than with lipids or blood pressure. Furthermore the evidence that drug reduction of HbA1c reduces cardiovascular endpoints is limited to metformin and possibly some sulphonylureas. There is no substantive evidence that more intensive glycaemia treatments, either with insulin or with the new oral agents improve mortality of CVD outcomes. In fact intensive treatment to reduce HbA1c below 7.5% with insulin and the new oral agents is now associated with increasing evidence of harm.

For patients with diabetes therefore, it is important to ensure that life-style messages (diet, exercise, giving up smoking) are emphasised at each review and concordance is checked whenever possible as these will have a major impact on improving their condition. Patient expectation should also be managed especially when initiating a new therapy. A reduction in their HbA1c will not be of major benefit if other useful interventions are ignored.

The best evidence we have of drug treatment in T2 diabetes to reduce events shows that in 5 years, 1 CVD event is prevented if

- 34 patients take antihypertensives (BP 10/5mmHg lower)  
- 44 patients take statins (cholesterol 1mmol/l lower)  
- 119 patients take metformin (HbA1c 0.9% lower).

Considering the cost of the newer agents it is important that we ensure we are using them in accordance with NICE guidance and their use is benefiting the individual patient. High cost of prescribing doesn’t necessarily mean patients are being looked after better as the graph below demonstrates. There is no correlation between high cost and better achievement.

GPs in Haringey HbA1c achievements for March 2013 have been plotted against their standardised cost of oral antidiabetic prescribing. The good news is majority of practices are in the low cost high achieving quadrant.
How to achieve this indicator
GPs will be asked to survey how they are using these medicines and their adherence to NICE guidelines. Non adherence to NICE should be documented for discussion with specialists in diabetes care. The results of the survey are to be submitted by 31 March 2014.

GPs will be invited to attend an educational event on the management of type 2 diabetes organised by the Medicines Management Team. All practices will be expected to send at least one representative to the training event.

Indicator 3: ScriptSwitch Performance
- Ensure Scriptswitch is activated appropriately
- Review a 6 month practice report and agree action points
- Suggest three areas of improvements e.g. where savings can be made or where recommendations of alternative preparations will result in savings.

Target:
Actions completed and report submitted by 31 March 2014

Rationale for Indicator
ScriptSwitch enables the Medicines Management team to provide evidence based information right at the point of prescribing, aiding the prescriber to follow guidelines without the need to remember or locate the numerous information sources. The use of ScriptSwitch® should reduce the pressures placed on the prescriber’s workload, support locum prescribers and improve patient care. The following areas detail where ScriptSwitch® will be useful:

- Informing prescribers of local initiatives and formulary choices
- National prescribing recommendations such as NICE and SIGN guidance,
- Dosage optimisation
- Communicating messages that ensure the quality and cost effectiveness of prescribing is maintained
- Imparting patient safety (e.g. NPSA Alerts) and “traffic light” drug information messages as they are released
- Communicating messages that contribute to prescribing savings
To improve Scriptswitch Performance in the Practice and across the CCG the following actions should be implemented:

1. All PC terminals where prescribing occurs should be checked after any server installation work and every 6 months to ensure that ScriptSwitch is activated on that individual PC. For EMIS LV, PCS Release 2 and EMIS Web users all enabled users should be checked.
2. A report for April to September 2013 will be sent to each practice. The practice should share the report with all prescribers.
3. Up to three ACTION POINTS for prescribers should be agreed and circulated to all prescribers with the report.
4. Up to three suggestions for improving Scriptswitch messages should be sent to the Medicines Management team e.g. where savings can be made or where recommendations of alternative preparations will result in savings.
5. The outcomes of action points to be documented.

The Medicines Management Team will circulate a Scriptswitch Practice Performance Toolkit and a short template for recording action points and outcomes which should be submitted to the team by 31 March 2014.

<table>
<thead>
<tr>
<th>Indicator 4: Practices to work with prescribing advisers on suggested projects; over a defined fixed time period with agreed outcomes. Areas covered will be around the “Organisational Domain” medicines management aspect of 12/13 QoF</th>
<th>Target: Evidence that GPs have worked collaboratively with prescribing advisers</th>
</tr>
</thead>
</table>

**Background**

The Haringey Medicines Management Team (MMT) have worked closely with GPs to continually raise the quality, safety and cost effectiveness of medicine use, to improve the uptake of evidence based and rational prescribing, identifying and rectifying unmet pharmaceutical need and inappropriate or unsafe pharmaceutical use in patients, and supporting understanding and concordance with prescribed medication and regimes.

It is well established that prescribing advisers working closely with GPs can improve prescribing efficiencies, assess prescribing effectiveness, influence prescribing behaviour, and reduce the number of medicines that are wasted, ref PRaCTICE study, EQUIP study, review of care homes.

Two-thirds of prescriptions generated in primary care are for patients who have requested a repeat supply of medicines they take regularly; this represents some 80% of medicines costs. It is estimated that 2.4 million prescriptions are issued each day in England, meaning that approximately 1.92 million prescriptions are issued each day for repeat items. It is therefore important to general practice staff and patients that an efficient and effective repeat prescribing system is in place. The medicines management team plans to focus on improving repeat prescribing processes in practices by increasing their support to practices.

Most importantly prescribing advisers, during their work at the practice will be screening patients for suitability to go onto repeat dispensing with the aim to free up GP and practice staff time so they can focus on managing long term conditions. The employment of two further prescribing advisers has been funded by the Primary Care Strategy for the purpose of assisting practices in making simple interventions for accelerated release of savings and freeing up GP and practice staff time to enable GPs to focus on managing long term conditions.

**Areas in GP practices prescribing advisers will cover**

- Identifying stable patients suitable for repeat dispensing (batch prescribing) and inviting patients onto the service
- Examine practice prescribing data, identify outliers and support those practices in making evidence based changes
- Medication review of patients over 75 taking four or more medicines
- Training of reception and administrative staff on repeat prescribing processes
Ensuring the practice are maximising their savings by ensuring their medicine management QIPP targets are met

References

Indicator 5:
- Review the use of high dose inhaled corticosteroids in asthma
- Ensure Patients on steroids (especially high doses) are being offered and counselled on using a spacer and this is recorded in notes and routinely monitored
- Use cost effective products when possible (Fostair)

Rationale for indicator

Summary
Following on from the “Haringey Respiratory Project” (HaRP) work carried out in 2011-2012, positive changes have been noted in Haringey GP respiratory prescribing habits. Since this time the cost of inhaled corticosteroids (ICS) has come down by £17,350. This saving is partly due to the increased usage of the cost effective ICS Fostair, for which prescribing has increased by 29% over the last 2yrs and a corresponding small decrease in the number of Seretide 250 evohaler devices. Has been realised despite an increase in inhaler costs, there has also been a corresponding small decrease in the number of Seretide 250 evohaler prescriptions. This saving has been realised despite an overall increase in total inhaler costs.

![Percentage High Dose Inhaled Steroids of all Inhaled Steroids by practice Dec 2012 to Feb 2013](image)

Between August and November 2011 the number of Spacers prescribed increased by 50%, this has now plateaued as the prescribing of spacers is not a recurrent need. These results show that the key messages from the training were well received by healthcare professionals in Haringey. This indicator has been chosen to help maintain the good work being carried out in this area but this time with a focus on asthma.

Background

What are the issues here?
High doses of inhaled corticosteroids (ICS) are associated with an increased risk of systemic side effects, including adrenal suppression and growth retardation in children. Stepping down therapy once asthma is controlled is recommended, but often not implemented leaving some patients over-treated.
What would good practice look like?

- All patients should be maintained on the lowest possible dose of ICS which effectively controls their asthma symptoms.
- Use of high dose ICS should be considered in only a small proportion of patients with asthma.
- Reductions in ICS dose should be considered every three months, decreasing the dose by 25 to 50% each time, where clinically appropriate.
- Children’s growth (height and weight centile) should be monitored annually.

Why is this important?

- Safety warnings have been issued about the use of high dose ICS, particularly in children and in relation to fluticasone.
- UK primary care data suggest that although prescribing of high dose ICS in children has reduced, high doses are still used in a minority of children, including children classified as having mild or intermittent asthma.
- Adverse effects associated with long-term ICS use are rarely monitored.
- Stepping down ICS dose can be achieved without compromising asthma control.

What can we do?

- Inform all patients (and their carers) about the important benefits and safety issues of ICS.
- Review the use of ICS routinely in patients with asthma, particularly in children and those on high doses.
- Step down the dose and use of ICS where clinically appropriate in patients with asthma. Review patients regularly as they step down.
- Provide steroid cards routinely for patients on prolonged treatment with high doses of ICS.

Note: ‘High dose ICS’ refers to doses used at Step 4 of the SIGN/BTS asthma guideline i.e. 800–2000 micrograms/day in adults; 400–800 micrograms/day in children aged 5–12 years (*beclometasone or equivalent).

Supporting Facts

Efficacy

- Standard dose ICS (200–800 micrograms/day in adults; 200–400 micrograms/day in children ≤12 years) are the first choice preventer drug for both adults and children.
- In mild to moderate asthma, starting at very high doses of ICS and stepping down is not beneficial.
- Doubling the dose at time of exacerbation is not recommended.

Safety

- High dose ICS carries a risk of systemic side-effects e.g. adrenal suppression, growth retardation, decrease in bone mineral density, cataract and glaucoma.
- Psychological or behavioural effects may also occur e.g. hyperactivity, depression and aggression (particularly in children).
- Fluticasone potency is double that of beclometasone or budesonide.

Cost

- Higher strength ICS formulations are typically more expensive within single or combination inhaler brands.
- If a combination inhaler is chosen, the least costly device that is suitable for the individual is recommended. Haringey CCG recommends Fostair (asthma: 1-2 inhalations twice daily - maximum 4 inhalations per day)
- Stepping down to lower strength inhalers may bring cost-savings, in addition to reducing the risk of dose-related ICS adverse effects.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Cost per 28 days</th>
<th>Cost per annum (365 days)</th>
<th>Cost based on dose of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fostair® MDI</td>
<td>£29.32</td>
<td>£382.21</td>
<td>2 inhalations BD, unlicensed in COPD</td>
</tr>
<tr>
<td>Seretide® 250 Evohaler</td>
<td>£59.48</td>
<td>£775.36</td>
<td>250/25 2 puffs BD, unlicensed in COPD</td>
</tr>
<tr>
<td>Seretide® 500 Accuhaler</td>
<td>£40.92</td>
<td>£533.42</td>
<td>500/50 1 puff BD</td>
</tr>
<tr>
<td>Symbicort® 200 Turbohaler</td>
<td>£38.00</td>
<td>£495.36</td>
<td>2 puffs BD</td>
</tr>
<tr>
<td>Symbicort® 400 Turbohaler</td>
<td>£38.00</td>
<td>£495.36</td>
<td>1 puff BD</td>
</tr>
</tbody>
</table>

**Patient factors**
- When stepping down, consider the severity of asthma, side-effects, time on current dose, beneficial effect achieved and patient preference.¹
- Choice of inhaler device — ICS metered dose inhalers (MDI) are as effective as ICS dry powder inhalers.¹ A spacer should be used for high dose ICS delivered via MDI¹. Using a spacer increases the efficacy of the inhaled medication as it ensures that the drug is getting to the right place and minimises side effects and waste.¹
- Combination inhalers may offer less flexibility for dose titration and stepping down, but may improve compliance.

**Other Notes**
- Remember to check inhaler technique of all asthma and COPD patients at every opportunity.
- Inhalation should be:
  - **GENTLE for a device that creates the aerosol for you** (e.g. metered dose inhalers such as Salbutamol and Seretide evohaler)¹
  - **FORCEFUL for a device that relies on the energy of inhalation** (e.g. Dry powder inhalers, Seretide Accuhaler, Symbicort, Tiotropium handihaler etc.)¹

(Poor knowledge of how drugs and inhalers work amongst patients are contributory factors in up to half of the 1400 fatal cases of asthma in the UK each year² [http://www.asthma.org.uk/news/news104.php].)

Inhaler Patient Information Leaflet can be found here [http://www.haringey.nhs.uk/MedicinesOptimisation/Patient%20Information/Inhalers%20for%20Asthma%20and%20COPD.pdf].

**References:**
1. SIGN/BTS. British guideline on the management of asthma. May 2008, revised May 2011
Indicator 6:

a. Reduce prescribing of 9 “Grey List” medicines for which cost-effective alternatives exist or which have limited clinical value
   i. Non Sumatriptan triptans
   ii. Venlafaxine MR
   iii. Quetiapine MR
   iv. Prednisolone EC
   v. Quantities of phosphodiesterase type-5 inhibitors for erectile dysfunction
   vi. Bath emollients
   vii. Doxazosin MR
   viii. Glucosamine
   ix. Fexofenadine

Target: ≤ £125 per 1000 Astro-PU per Quarter

b. Compliance with recommended 1st Beclomethasone, 2nd Budesonide and 3rd line fluticasone choice of intranasal steroid

Target: Beclometasone & budesonide equal to or more than 60% of intranasal steroids

The grey list consists of drugs with limited clinical value or where more cost effective alternatives exist. Practice spend on grey list drugs varies across the CCG and ranges from £0 to £258 per 1000 Astro PU. A target of less than £125 per 1000 Astro PU, has been set and practices are encouraged to reduce prescribing to below this level by 31st March 2014.

This can be achieved by reviewing and changing patients currently on these medicines to more cost effective alternatives and not initiating these medicines except in exceptional cases, if clinically appropriate.

Grey List Cost per 1000 Astro PU for October to Dec 12. Target: Below £125 per 1000 Astro PU

a. Grey List Rationale

i. Non Sumatriptan triptans:

Reduce prescribing of Non Sumatriptan triptans and change patients to sumatriptan 50mg if they have not trialled sumatriptan before.

NHS evidence (CKS) recommends that, for most people, oral Sumatriptan at a dose of 50mg or 100mg should be tried first before trying other Triptans. Although the 100mg dose has been the most extensively studied Triptan regimen, it is only marginally more effective than the 50mg dose and has more adverse effects.

The Triptans (selective serotonin 5-HT1 agonists) are very effective acute migraine drugs. There are currently 7 Triptans in the UK licensed for the treatment of migraine. At marketed doses, all oral Triptans...
are effective and well tolerated and clinical differences among them are in general relatively small. In the Triptan –naive patient, it is unlikely these differences can be used to guide prescribing. Patient response to treatment varies and if treatment with one Triptan fails to control the migraine, it is worth trying another Triptan. All Triptans are contra-indicated in the presence of cardiovascular disease.

- Sumatriptan is the most cost-effective triptan and the 50mg dose is also available over the counter.
- There is good evidence on the comparative effectiveness and tolerability of Triptans from several meta-analyses (table1).

Table 1. RELATIVE EFFECTIVENESS AND TOLERABILITY OF THE TRIP TANS.

<table>
<thead>
<tr>
<th>Triptan and strength</th>
<th>Response rate</th>
<th>Pain free rate</th>
<th>Consistency</th>
<th>Tolerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sumatriptan 25 mg</td>
<td>–</td>
<td>=/–</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>Sumatriptan 50 mg</td>
<td>=</td>
<td>=</td>
<td>=/–</td>
<td>=</td>
</tr>
<tr>
<td>Zolmitriptan 2.5 mg</td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>Zolmitriptan 5 mg</td>
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<td>=</td>
<td>=</td>
</tr>
<tr>
<td>Naratriptan 2.5 mg</td>
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<td>–</td>
<td>++</td>
</tr>
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<td>Rizatriptan 5 mg</td>
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</tr>
<tr>
<td>Rizatriptan 10 mg</td>
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<tr>
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<td>Eletriptan 40 mg</td>
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<tr>
<td>Eletriptan 80 mg</td>
<td>++</td>
<td>+</td>
<td>=</td>
<td>–</td>
</tr>
<tr>
<td>Almotriptan 12.5 mg</td>
<td>=</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
</tbody>
</table>

(=) no difference compared with sumatriptan 100 mg   (+) better than sumatriptan 100 mg   (–) inferior to sumatriptan 100 mg

References

ii. Venlafaxine MR:

For Venlafaxine use in major depression, the BNF recommends starting treatment at 75mg in two divided daily doses with an immediate release (IR) preparation, a number of which are generically available.¹

Various manufacturers produce modified release (MR) preparations, most of which are capsules, licensed for once daily administration for depression. Some of the MR capsule products are also licensed for use in Generalised Anxiety Disorder (GAD), Social Anxiety Disorder (SAD) and panic disorder (see licensed indications table below). The MR preparations were commercially developed subsequent to the development of the IR preparation for depression and permit once a day dosing compared to the twice a day dosing for the IR preparation. Studies have found no worthwhile or significant difference in levels of compliance between once daily and twice daily regimens. In some circumstances missing a dose may be more serious with a once daily slow-release product than with a standard formulation taken twice a day. Ref DTB 1991 Vol. 29 No.1

All new patients should be started on Immediate Release Venlafaxine tablets and titrated to an appropriate effective dose where they would be maintained. Patients should only be changed to MR tablets where compliance or side effects are an issue and reasons clearly documented in their notes.

A report from the MHRA shows that bioequivalence between both MR tablets and MR capsules is satisfactorily demonstrated and the SPC of both products states that the bio-availability is the same, which means that existing patients using capsules can be switched to tablets without any extra monitoring. New patients will not notice the difference.²
### Licensed indications for the various Venlafaxine preparations

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Licensed indications</th>
</tr>
</thead>
</table>
| Venlafaxine m/r capsules | 1. Treatment of major depressive episodes.  
                          | 2. For prevention of recurrence of major depressive episodes.  
                          | 3. Treatment of generalised anxiety disorder.  
                          | 4. Treatment of social anxiety disorder.  
                          | 5. Treatment of panic disorder, with or without agoraphobia. |
| Venlafaxine m/r tablets | Treatment of major depressive episodes                                                   |
| Venlafaxine i/r tablets | Treatment of major depressive episodes  
                          | For prevention of recurrence of major depressive episodes |

Significant cost savings with no significant patient impact can be achieved by undertaking the following changes:

<table>
<thead>
<tr>
<th>Change from:</th>
<th>To:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venlafaxine MR Capsules or Venlafaxine MR Tablets</td>
<td>Twice daily immediate release tablets</td>
<td>Change can be made by the GP at next consultation with the patient. The prescriber must be aware of the different licenses that cover each preparation. The decision to change patients to a preparation where a particular indication is off license must be understood by the prescriber.</td>
</tr>
</tbody>
</table>

Existing patients taking Venlafaxine MR capsules or MR tablets should be changed to the equivalent immediate release dose. Unless they fall into one of the following categories:

- Patients with a contraindication to immediate release venlafaxine tablets
- Breast feeding patients or pregnant patients already established on MR Venlafaxine
- Patients with compliance issues
- The immediate release formulation is not licensed for the indication

References:
2. MHRA Product Licence Approval Document for two brands of Venlafaxine MR Tabs. 2008  
   [http://www.mhra.gov.uk/SearchHelp/GoogleSearch/index.htm?q=venlafaxine&oq=venlafaxine&aq=f&aqi=g10&aql=1&gs_sm=3&gs_upl=734315390102009311212104414042218923.31250&gs_l=partner.3..0l10.734315390102009311212104414042218923.31250gsnos%2Cn%3D13.1](http://www.mhra.gov.uk/SearchHelp/GoogleSearch/index.htm?q=venlafaxine&oq=venlafaxine&aq=f&aqi=g10&aql=1&gs_sm=3&gs_upl=734315390102009311212104414042218923.31250&gs_l=partner.3..0l10.734315390102009311212104414042218923.31250gsnos%2Cn%3D13.1)

### iii. Quetiapine MR:

Minimise the use of Quetiapine modified release (MR) in favour of the immediate release (IR) preps. When generic oral Quetiapine became available a year ago the price of the plain tablets eventually fell by approximately 93%. This resulted in a significant saving for any patient stabilised on the IR tablet. The cost of the MR/XL preparations have not changed.

In 2012/13 we are predicted to spend about £96k (compared to £223k in 11/12) on the IR preparation and £131k (compared to £95k in 11/12) on the MR/XL preparation.

If the usage of the XL preparation could be minimised in favour of the IR preparation so that 80% of the current XL usage could be changed to the IR preparation, **£98k could be saved**.

Taking these potential savings into consideration the BEH Mental Health Trust approved the following actions at its March 2012 DTC meeting.

1. Because IR Quetiapine is licensed for once daily dosing for the treatment of depression in bipolar disorder it is not unreasonable to use IR once daily for other indications, something already done in other trusts. If once daily dosing is used it is best given in the evening to minimise side-effects.
2. Because initiation with XL quetiapine has simplified the use of the drug, the XL preparation can be used on days 1 and 2 of the initiation before transferring to the IR preparation on day 3.
3. Following the first 2 days of initiation once daily IR quetiapine should then be used and only if unacceptable side-effects are encountered should a trial of maintenance-dose XL be considered.
4. If patients are currently stabilised on the XL preparation, if not already tried, a switch to trial once daily IR should be undertaken with a view to moving away from XL.
5. If adherence to treatment is not seen as an issue, e.g. medication is being administered by a carer, then twice daily IR dosage can be used in preference to the XL preparation.

A patient information leaflet has been produced to accompany the changing of stable patients over from XL to IR. This is available from your prescribing adviser. Please make sure any communication details the formulation clearly so pharmacists are clear with regards to which formulation is requested during the dispensing process.


iv. Prednisolone EC

There is no evidence that enteric coated prednisolone tablets confer patient safety or clinical benefits over standard uncoated presentations.

Evidence comparing preparations is sparse; however, two historic high-quality reviews by the Drugs and Therapeutics bulletin investigated the issue with a comprehensive recent search by UK Medicines Information (UKMi) revealing limited additional publications

Quality issues
The UKMi summary identified two issues potentially affecting choice between preparations: risk of peptic ulceration and pharmacokinetics/bioavailability. To take each in turn:

Peptic ulceration
• Oral corticosteroid use is weakly linked with ulceration, with level of risk dependent on individual patient characteristics; however, risks are small compared with the potential benefits of appropriately prescribed therapy
• There is no convincing evidence that enteric coated (EC) prednisolone reduces the risk of peptic ulceration or dyspepsia compared with uncoated alternatives
• The likely mechanism of steroid induced ulceration is systemic suggesting negligible value of enteric coatings

Pharmacokinetics/bioavailability
• EC tablets may be associated with less predictable absorption than uncoated alternatives, with authors suggesting uncoated tablets better ensure stable and predictable drug exposure

Productivity issues
• From a cost-effective prescribing perspective, use of enteric coated prednisolone in preference to uncoated tablets represents a significant lost opportunity across London.
• The disparity in prices for individual products as is follows (taken from March 2013 Drug Tariff)

<table>
<thead>
<tr>
<th>Prednisolone EC 5mg x 28 = £3.76</th>
<th>Prednisolone EC 2.5mg x 28 = £3.76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prednisolone (uncoated) 5mg x 28 = £0.96</td>
<td>Prednisolone (uncoated) 1mg x 28 = £0.78</td>
</tr>
</tbody>
</table>

Recommendations
Enteric coated prednisolone is neither clinically nor financially appropriate; we recommend the following actions:
• Existing patients taking EC tablets should be reviewed and changed to uncoated tablets where prednisolone remains appropriate
• All new patients requiring prednisolone should be initiated ONLY on uncoated tablets.
• Patients requiring a 2.5 mg dose or dosing interval should be prescribed uncoated prednisolone 5 mg tablets since these are scored and can be easily halved.

v. Large Quantities of Phosphodiesterase type-5 inhibitors (PDE-5 inhibitors: Sildenafil, Tadalafil and Vardenafil) prescribed on FP10’s
The prescribing of PDE-5 inhibitors has been increasing each year and in 2012/13 Haringey is forecast to spend £338,000 on this class of drug. During routine monitoring we have identified two concerns:

- some prescribers are issuing large quantities
- the use of the less cost effective agents

DOH guidance recommends that doctors should normally restrict their prescribing of treatment for impotence to one treatment per week (4 per month), in accordance with research evidence which showed that the average frequency of sexual intercourse in the 40-60 age range is once a week. Prescribers are reminded to check whether patients requesting this class of drugs fit the SLS criterion as laid out in the BNF. Patients falling outside the criterion can be prescribed these agents on a private prescription.

NB: We have removed sildenafil from the calculation of cost per Astro-PU as this will become available generically in June 2013 and will distort the figures. Sildenafil will become a cost effective alternative in this class and prescribing it instead of the other agents will generate savings.

The frequency of contra-indications with these drugs increases with age and prolonged prescribing could mask the progression of serious underlying disease. Some psychological causes of erectile dysfunction resolve spontaneously or with treatment, so the need for and tolerance should be reassessed at 1-3 months. Thereafter the appropriateness of prescribing should normally be checked yearly, but stopped immediately if interacting drugs have to be prescribed for other conditions.

Ref:

vi. Bath emollients: The BMJ, November 2009, reported that there are uncertainties surrounding the use of bath emollients as part of the treatment of atopic eczema as there is no published evidence from randomised controlled clinical trials evaluating the efficacy of bath emollients in the treatment of patients with atopic eczema. Topical emollients applied directly to the skin are effective and key in the management of patients with atopic eczema, and there is long clinical experience and some published evidence to justify such use. The same cannot be said of bath emollients. The quantities of emollient deposited on the skin during bathing are likely to be far lower than directly applied emollients.

Based on data for this financial year (up to quarter 3) it is predicted that Haringey CCG will be spending £396k on all emollients and £67k on bath emollients. This cost, coupled with the lack of evidence has generated the need to continually review their use.

The Medicines Management Team recommends that practices continue to review patients using bath emollients with the view to stopping these products and replacing them with soap substitutes like Aquamax and Ultrabase cream or Emulsifying Ointment. To maximise efficacy GP’s need to ensure patients are applying topical emollients liberally and frequently.

Some Unwanted effects of Bath Emollients
- Irritation or allergic contact dermatitis has occasionally been associated with use of bath emollients containing antimicrobials.
- Bath emollients can also leave a greasy film in the bath making baths slippery, which may lead to accidents and making the bath more difficult to clean


vii. Doxazosin XL:
Doxazosin is a long acting alpha-1 adrenergic blocker which is licensed for the treatment of hypertension. It is available as both immediate and modified release tablets. (1) The immediate release (standard) preparation is initiated at 1mg once daily increasing to a maximum of 16mg daily. The modified release preparation is initiated at a dose of 4mg daily, increasing to 8mg daily as necessary. (1) Doxazosin modified-release is available as branded Doxazosin XL and generic forms, such as Doxadura XL. (1)

Reformulation
Doxazosin XL is a reformulation of the immediate release preparation. Reformulation occurs when an active substance is usually combined with other substances to generate a final product (such as a tablet). The formulation influences how the drug is absorbed. Slowing absorption by reformulating the medicine as
a modified release preparation may be beneficial if, for example, it reduces dosing frequency and thereby improves adherence. Towards the end of its patent term, the α blocker doxazosin was reformulated as a modified release preparation, Doxazosin XL. Although their release characteristics differ, both formulations are administered once daily and they are similarly effective. When Doxazosin XL was introduced, the commonly used Doxazosin 4 mg tablet was withdrawn. Prescribers were advised instead to use Doxazosin XL, which was dosed differently. This resulted in substantial spending on Doxazosin XL, despite generic doxazosin entering the market a short time later.

The MR preparation therefore has no compliance gain over the standard tablets. Yet the MR tablet is over 4 times the price of the standard tablet.

Doxazosin XL 4mg = £5.00 for 28 tabs
Doxazosin XL 8mg = £9.98 for 28 tabs
Doxazosin 4mg = £1.22 for 28 tabs
Prices from April 2013 Drug tariff

If all XL tablets were switched to IR tablets we could save **£69K** annually.

**References**

2. UKMI Q&A 22, A comparison of doxazosin standard with doxazosin GITS. Available at [www.nelm.nhs.uk](http://www.nelm.nhs.uk)

**viii. Glucosamine:**

NICE specifically states that "The use of Glucosamine or Chondroitin products is NOT recommended for the treatment of Osteoarthritis"

Glucosamine sulphate 1.5g tablets = £18.20 for 30 tabs.
Glucosamine sulphate 500mg/chondroitin 400mg tabs = £37.53 for 30 tabs

Ref: [http://www.nice.org.uk/nicemedia/live/11926/39720/39720.pdf](http://www.nice.org.uk/nicemedia/live/11926/39720/39720.pdf)

**ix. Fexofenadine:**

Cetirizine and Loratidine 10mg are better value for money and should be prescribed instead

**Drug Tariff March 2013 Prices**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Price</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cetirizine 10mg</td>
<td>£0.89</td>
<td>30</td>
</tr>
<tr>
<td>Loratidine 10mg</td>
<td>£1.03</td>
<td>30</td>
</tr>
<tr>
<td>Fexofenadine 120mg</td>
<td>£4.45</td>
<td>30</td>
</tr>
</tbody>
</table>

**b. Compliance with Recommended 1st, 2nd and 3rd Line Choice of Intranasal Steroid**

Six intranasal steroids are available for the treatment of allergic rhinitis in the UK and are administered either once or twice daily. Comparison results show that they are all equally effective in controlling the symptoms of allergic rhinitis, both intermittent and persistent 1. As they are all equally effective, it would seem prudent to prescribe the least expensive intranasal steroid that suits the patient.

Beclometasone 50mcg nasal spray **200 dose** is the most cost effective **TWICE daily** intranasal steroid at £2.35 per pack while budesonide 64mcg 120 dose is the most cost-effective **ONCE daily** intranasal steroid at £3.85 per pack. The way in which the prescription is written is also important as can be seen from the price difference between the 180 dose and 200 dose beclometasone. There is also a significant price difference between the 100mcg and 64 mcg budesonide.
<table>
<thead>
<tr>
<th>BNF Name</th>
<th>Brand name</th>
<th>Number of doses per pack</th>
<th>Duration in days if using maintenance dose</th>
<th>Cost to NHS per pack (Dec 2012)</th>
<th>Cost to NHS per day in pence (Daily maintenance dose)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beclometasone 50microg nasal spray (200 dose)</td>
<td>Beconase</td>
<td>200</td>
<td>50</td>
<td>£2.34</td>
<td>5</td>
</tr>
<tr>
<td>Beclometasone 50microg nasal spray (180 dose)</td>
<td>Beconase hayfever</td>
<td>180</td>
<td>45</td>
<td>£5.78</td>
<td>13</td>
</tr>
<tr>
<td>Budesonide 64microg nasal spray</td>
<td>Rhinocort Aqua</td>
<td>120</td>
<td>60</td>
<td>£3.81</td>
<td>6</td>
</tr>
<tr>
<td>Budesonide 100microg nasal spray</td>
<td>Non-proprietary</td>
<td>100</td>
<td>50</td>
<td>£5.90</td>
<td>12</td>
</tr>
<tr>
<td>Triamcinolone acetonide 55 microg nasal spray</td>
<td>Nasacort</td>
<td>120</td>
<td>60</td>
<td>£7.39</td>
<td>12</td>
</tr>
</tbody>
</table>

Increasing beclometasone and budesonide from 40% (Feb 2013) to 60% intranasal steroids will save £40,000 a year.

**Recommended Intranasal Steroids for Allergic Rhinitis**

Adults & children over 12 years: 1st/2nd choice: Beclometasone or budesonide, 3rd choice Fluticasone

Children aged 4-6 years: 1st choice: Fluticasone (licensed option), 2nd choice triamcinolone (Nasacort licensed for children from 2 years)

Children aged 6-12 years: 1st choice: Beclometasone, 2nd choice: Fluticasone

Avamys and Nasofan brands of fluticasone are lowest cost brands.

**References**

1. London New Drugs Group (APC/DTC briefing document Intranasal corticosteroids for allergic rhinitis February 2008)
   http://www.nelm.nhs.uk/en/Download/?file=MDs0OTUwNzI7RXZpZGVuY2UvRHJ1ZyBTcGVjaWZpYyBpYSZXZpZXdZd0ludHJhbmFzYWQwQ3Rlc3Rhcm9pZHMiLiBUaW1hbmNlLUA4LiBNbGZg___.pdf
2. Allergic rhinitis Prescribing information; Which intranasal corticosteroids should I use to treat allergic rhinitis? Accessed 08/09/2011
   http://www.cks.nhs.uk/allergic_rhinitis/prescribing_information/intranasal_corticosteroids/drug_choice

**Indicator 7: Oxybutinin and tolterodine immediate release (IR) as 1st line choice.**

Use Oxybutinin and Tolterodine IR as 1st line choice for urinary frequency.

**Target:**

Equal to or more than 26% items of all urinary frequency drugs

**Background**

Urinary incontinence is a common problem, with a mean annual incidence of 1 to 9 per cent and estimates of remission ranging from 4 to 30 per cent. National Institute for Health and Clinical Excellence guidelines recommend bladder training as first-line treatment. If this is not effective, antimuscarinics should be offered with regular review. Anecdotal evidence suggests medication is often continued long-term without consideration of effectiveness, adverse effects or patients’ perceptions of success.

Long-term prescribing of antimuscarinics is associated with an increased risk of cognitive impairment and mortality. Benefits from medication are small, with fewer than 200 cases of continence attributable per 1,000 treated. Patients may, therefore, be taking treatment with limited benefit and an increased risk of adverse effects.
Rationale for Indicator

- Overactive bladder syndrome (OAB) is characterised by urgency that occurs with or without urge urinary incontinence and usually with frequency and nocturia. Treatment of OAB may include lifestyle interventions (e.g. fluid modification), physical therapies (e.g. pelvic floor muscle training), bladder training and drug therapies (e.g. antimuscarinic drugs).

- NICE guidance on the management of urinary incontinence in women recommends offering immediate release generic oxybutynin as first-line drug treatment if bladder training has been ineffective. This recommendation was based on cost effectiveness as there was no evidence of a clinically important difference in efficacy between antimuscarinic drugs.

- When an antimuscarinic drug is prescribed for OAB it is recommended to undertake a review after 6 months to assess the balance between beneficial and adverse effects. If beneficial, review treatment after 6 months to assess whether it is still needed. Consider a ‘drug holiday’ for four weeks, and if successful discontinue treatment. Some patients will be able to manage long term without medication with no further problems.

- If all practices prescribed oxybutynin and tolterodine IR at a rate of 26% of all drugs for urinary frequency the CCG will save £58,000 a year.

References