Prescribing Quality and Savings Scheme 2017/18

The 2017/18 Prescribing Quality and Savings Scheme (PQSS) builds on previous years schemes and aligns with the National, London and Haringey Quality, Innovation, Productivity and Prevention (QIPP) agenda and North Central London Strategic and Transformation Plan priorities.

The purpose of the scheme is:
To encourage and reward medicines optimisation, 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 prescribing.
- The scheme is designed to support financial stability without compromising patient care.
- The scheme should encourage Practices to consider how patients can be supported to get the best from their medicines, and how they can benefit from cost-effective quality prescribing.
- 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 facilitate change. The Medicines Management Team (MMT) is able to provide advice and support to practices to implement the scheme.
- The scheme will run from 1st April 2017 to 31st March 2018. Audits can be submitted up to 30th April 2018. Any submissions after that date will need to state why the deadline was missed and whether there were mitigating circumstances. These will be considered by the Medicines Optimisation Committee.

Due to the high 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 PQSS budget. For the 2015/16 PQSS scheme, practices received an average of £7,400 (ranging from £0-£37,600).

Summary of the Scheme

- **Entry Criteria (all Practices)**: Achieve or maintain antibiotic prescribing targets and submit data to the national diabetes audit
- **Section A (all Practices)**: Patient reviews: £94,500 (approximately 2,000 patient reviews)
- **Section B (all Practices)**: Working with prescribing advisers to implement cost effective prescribing in QIPP areas.
- **Section C (for Practices not completing Section D)**: Repeat prescribing, self-care, hypnotics and acute kidney injury
- **Section D ONLY** Practices supporting care homes and where a repeat prescribing audit has identified high levels of waste
Options for Payment: Additional support from 3 prescribing advisers will be available to Practices in 2017/18. Practices may choose from 3 options depending on how much support they would like.

<table>
<thead>
<tr>
<th>Option One</th>
<th>Option Two</th>
<th>Option Three</th>
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<tbody>
<tr>
<td><strong>Section A (all Practices):</strong> Patient reviews: £94,500 (approximately 2,000 patient reviews) is ring-fenced for patient reviews.</td>
<td>Practices will be paid in the region of £30-£50 per patient reviewed (depending on the amount of time required and outcome), regardless of achieving an overall saving in their budget. The number of patients will be limited according to Practice list size.</td>
<td>Prescribing advisers will carry out patient reviews and share/discuss outcome/action with GP. Practices will be paid £15-£25 per patient reviewed, regardless of achieving an overall saving in their budget. The number of patients will be limited according to Practice list size.</td>
</tr>
<tr>
<td><strong>Patient review areas:</strong></td>
<td></td>
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<tr>
<td>1. Diabetes</td>
<td>Practices will be paid in the region of £30-£50 per patient reviewed, regardless of achieving an overall saving in their budget. The number of patients will be limited according to Practice list size.</td>
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<tr>
<td>2. Adults with asthma</td>
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<tr>
<td>3. Atrial Fibrillation</td>
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<td>4. COPD</td>
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<tr>
<td>Motivational interviewing techniques should be utilised here</td>
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<tr>
<td><strong>Section B (all practices):</strong> Working with prescribing advisers to implement cost effective prescribing QIPP areas. Achieving this indicator will realise 15% of the Practice’s savings.</td>
<td>Prescribing advisers will undertake audits and will support Practices to achieve targets, agree and implement action plans.</td>
<td>Prescribing advisers will undertake audits and will support practices to achieve targets, agree and implement action plans.</td>
</tr>
<tr>
<td><strong>Section C (for Practices not completing Part D):</strong></td>
<td>Achieving these indicators will realise 5% of the Practice savings.</td>
<td>Achieving these indicators will realise 5% of the Practice savings.</td>
</tr>
<tr>
<td>1. Repeat Prescribing (Part I)</td>
<td>Achieving this indicator will realise 5% of the Practice’s savings</td>
<td>Prescribing advisers will undertake audits and will support Practices to achieve targets, agree and implement action plans.</td>
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<tr>
<td>2. Promoting Self-care</td>
<td>Achieving this indicator will realise 5% of the Practice’s savings</td>
<td>Achieving these indicators will realise 5% of the Practice savings.</td>
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<tr>
<td>3. Hypnotic Prescribing Review</td>
<td>Achieving this indicator will realise 7.5% of the Practice’s savings</td>
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<tr>
<td>4. Reduce Risk of Acute Kidney Injury</td>
<td>Achieving this indicator will realise 7.5% of the Practice’s savings</td>
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<tr>
<td><strong>Section D: Practices supporting care homes and practices where a repeat prescribing audit has identified high levels of waste should focus on one of these areas</strong></td>
<td>Prescribing advisers will undertake audits and will support practices to achieve targets, agree and implement action plans.</td>
<td></td>
</tr>
<tr>
<td>1. Care Homes Prescribing Review OR Indicator 2. Repeat Prescribing (Part II)</td>
<td>Prescribing advisers will undertake audits and will support Practices to achieve targets, agree and implement action plans.</td>
<td>Achieving these indicators will realise 5% of the Practice savings.</td>
</tr>
<tr>
<td><strong>Total savings for Sections B-D</strong></td>
<td>40%</td>
<td>20%</td>
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</table>

- In addition to the indicators on the scheme, Practices may choose to work on additional opportunities, suggested by their prescribing adviser, to maximise savings.
- **If the practice savings exceeds the remainder of the available resources, £220,500, (i.e. £315,000-£94,500) the level of payments will be scaled down proportionately.**

Areas where prescribing advisers will support
Entry criteria to Section A of the scheme (all Practices)

**Antibiotic entry criteria**
Resistance to antibiotics is spreading, and now constitutes a major threat to the delivery of safe and effective healthcare. Antimicrobial resistance and antibiotic prescribing are inextricably linked; overuse and incorrect use of antibiotics are major drivers of resistance.

**How to Achieve Indicator**
Practices with high levels of prescribing of broad spectrum antibiotics and high overall levels of prescribing will need to achieve reductions in the volume of prescribing as part of the entry criteria to part 1 of the scheme. Resources from the TARGET antibiotic toolkit are available to achieve the targets.

A new indicator targets an increase in the appropriate use of nitrofurantoin as 1st line choice for the empirical management of UTI in primary care settings, and supports a reduction in inappropriate prescribing of trimethoprim which is reported to have a significantly higher rate of non-susceptibility in ‘at risk’ groups.

- Reduce the annual number of antibacterial items by 10% or to below 0.815 items/ oral antibacterial STAR-PU (item based).

- Reduce the annual number of items for quinolones, cephalosporins & co-amoxiclav per antibacterial STAR-PU by 10% or to below 0.095.
- Reduce the annual number of items for trimethoprim by 10% or to below 50% of the total items for trimethoprim and nitrofurantoin (nitrofurantoin is now 1st choice)
Background

The National Diabetes Audit is one of NHS England’s flagship international audits and is the largest of its kind in the world. Last year Haringey achieved a 95% participation rate its highest achievement yet, across the country participation in 2014-15 was 57.3% this is now 82.4% in 2015-16. There is a huge variation in achievement within CCGs and between CCGs in the country.

The data collected is analysed and use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes. Through participation in the audit, local services are able to benchmark their performance and identify where they are performing well, and improve the quality of treatment and care they provide. It is therefore important to participate annually.

A key finding for the 2015/16 run was younger people with either Type 1 or Type 2 and other diabetes are less likely to achieve all three treatment targets (HbA1c, Blood Pressure and Cholesterol) than their older counterparts. This is primarily due to poorer glucose and cholesterol control in those aged under 65 years. To improve this practices need to target their efforts on this age group. A Quality Improvement Toolkit has been developed in collaboration with the RCGP to help practices use their diabetes data to improve services [LINK](#).

How to achieve the NDA entry criteria:

1. Make sure the NDA have the correct contact details for the responsible practice staff – email name, email address, job title, practice name/CCG name, practice code/CCG code, clinical system (if applicable) send details to diabetes@nhs.net.

2. Once the NDA team have your contact details look out for NDA notification emails. These will include information about the submission window and what you need to do to opt in/participate in the audit.


4. The NDA website is always been updated so please keep checking

5. Contact GP IT should you have any problems prior to the collection.
### Summary of the Scheme

**ENTRY CRITERIA**

To qualify for this part of the scheme outlier Practices above the CCG target should:

- Reduce the number of antibacterial items antibacterial STAR-PU
- Reduce the items of quinolones, cephalosporins & co-amoxiclav per antibacterial STAR-PU
- Reduce the prescribing of Trimethoprim for UTIs (nitrofurantoin is now 1st choice)

All other Practices should maintain their rate of prescribing at or below the targets.

Engage with the National Diabetes Audit and submit data to the audit commissioner, Health Quality Improvement Partnership.

<table>
<thead>
<tr>
<th>MEASURE</th>
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<tbody>
<tr>
<td>• Reduce by 10% or to below 0.815 items/antibacterial STAR-PU</td>
</tr>
<tr>
<td>• Reduce by 10% or to below 0.095 items/antibacterial STAR-PU</td>
</tr>
<tr>
<td>• Reduce Trimethoprim items by 10% or to below 50% of the total Trimethoprim + Nitrofurantoin items</td>
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</table>

Use the following link:
http://content.digital.nhs.uk/nda_collection

### Section A (all practices): Patient reviews: £94,500 (approximately 2,000 patient reviews)

<table>
<thead>
<tr>
<th>A1. Improving Diabetes Outcomes. Use a search tool to identify all patients with poor HbA1c over past 12 months who have not had a recent intervention.</th>
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<tbody>
<tr>
<td>• Review patients using motivational interviewing techniques</td>
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<tr>
<td>• Take part in a Practice-Based Consultant lead Educational Programme or patient review session.</td>
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Payment per review
Initial MI plus first HbA1c: £30
Follow up+ recording 2nd HbA1c: £20
Prescribing adviser assistance (£15/10)

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<tr>
<th>A2. Adults with Asthma. Practice should:</th>
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<tbody>
<tr>
<td>• have in place a designated, named clinical lead for asthma services</td>
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<tr>
<td>• Use the PRIMIS’ asthma audit tool to improve asthma care and meet NRAD³ recommendations. Tool identifies patients needing review.</td>
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</table>

Payment Per Review £40
Prescribing adviser assistance (£20)

### A3. Atrial Fibrillation.

Review a list of patients that have been identified with atrial fibrillation from secondary care data that are not on the practice QOF atrial fibrillation register. Review diagnosis and assess for anticoagulation.

Payment Per Review £30
Prescribing adviser assistance (£15)

### A4. COPD

Use a PRIMIS search tool to interrogate clinical data, enabling the improvement of patient outcomes, reducing costs and avoiding inappropriate treatment for patients with COPD. Tool will identify patients to review.

Payment Per Review £50
Prescribing adviser assistance (£25)
### Section B (all Practices)

<table>
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<tr>
<th>MEASURE</th>
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<tbody>
<tr>
<td>To qualify for this part of the scheme practices should come within budget at year end. Adjustments will be made for genuine unforeseen changes.</td>
</tr>
<tr>
<td>Working with prescribing advisers to implement cost effective prescribing in QIPP areas.</td>
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<tr>
<td>Evidence that GPs have worked collaboratively with prescribing advisers</td>
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### Section C (for practices not completing Part D)

#### C1. Repeat Prescribing (Part I)
- Review 2016/17 repeat prescribing audit implement action plan
- Engage in activities to reduce patient over ordering of medicines e.g. using of posters and leaflets
- Appoint a practice medicines co-ordinator (PMC) to lead on repeat prescribing and to complete an e-learning package

#### C2. Promoting Self-care for Minor Ailments & Common Conditions
Encourage patients to be pro-active and reduce dependency on the NHS. Minimise the time spent by GPs on minor ailments and common conditions allowing for concentration on more complex health problems.

#### C3. Prescribing of Hypnotics
Review patients on hypnotics and consider dose reduction, stopping or change in hypnotic

#### C4. Reducing Acute Kidney Injury (AKI)
Use a risk assessment tool to identify patients who are at risk of AKI. Review need for nephrotoxic medicines and consider safer alternatives.
(1) Educate patients and carers about risk of dehydration during acute illness.
(2) Educate patients to seek help/advice early during acute illness.

### Section D: ONLY Practices supporting care homes and practices where a repeat prescribing audit has identified high levels of waste should focus on one of these areas

#### D1. Care Homes Prescribing Review
Produce and implement care home guide for NICE set criteria
- How prescription orders are taken, timescales for processing and collection
- How acute requests/mid-cycle changes are managed
- Notification/alerting staff of new medication/changes to directions for existing medications synchronise and bring repeat medications into line
- Medication reviews are up to date
- “When required” medication instructions are clear and repeats prescribed only when supply is depleted

#### D2. Repeat Prescribing (Part II)
For practices identified with high levels of over ordering of repeat medicines. Develop processes to reduce this.
Most patients should take responsibility for ordering their own prescriptions unless there are special circumstances or vulnerable patients.

A 5% reduction in over ordering
A 30% increase in patients ordering their own repeat medicines
50% of patients requesting repeat prescriptions through online ordering
### Part A

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure</th>
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<tbody>
<tr>
<td><strong>A1. Improving Diabetes Outcomes.</strong> Using motivational interviewing to promote adherence to hypoglycaemic medications:</td>
<td>Number of patients reviewed/ participate in motivational interviewing sessions, engagement with consultant educational sessions.</td>
</tr>
<tr>
<td>• Review patients with poor HbA1c over the previous 12 months who have not had a recent intervention and invite them for an intervention</td>
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<tr>
<td>• Practice to have had an educational session with a local consultant or difficult to manage patient review session within the year- minutes to be provided to the MMT</td>
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### Aim

To promote medication adherence in patients with type II diabetes by identifying uncontrolled patients and exploring with them what the cause of their poor HbA1c is. Those confirmed as adherent yet uncontrolled on first line treatment to be moved along the management pathway to reduce complications. The process will involve optimisation of lifestyle advice, motivational interviewing support, initiation of current oral or injectable therapies or “the right insulin at the right time and at the right dose”. Practices will be provided with tools e.g. EMIS/Vision searches to easily identify these patient and NCL. **Antihyperglycaemic Agents for T2DM**

### Background

Diabetes is a growing problem in Haringey and managing it and its compounding factors is becoming increasingly challenging. The prevalence of recorded diabetes in populations registered with GP practices aged 17 and over for Haringey, London and England is increasing year on year.

### How to achieve indicator:

1. Health care professionals (HCP) will be provided with EMIS/Vision search tools from the MMT (or you can use your own) to identify patients suitable (HbA1c> 64mmol/mol) for a review/motivational interviewing session.
2. If determined to be compliant with their medication yet uncontrolled on therapy (e.g. metformin or metformin & sulfonylurea) the HCP will need to move the patient along the management pathway to reduce long term complications. **Antihyperglycaemic Agents for T2DM**
3. Optimisation of lifestyle advice, motivational interviewing support see (MI tool kit), initiation of current oral or injectable therapies **Antihyperglycaemic Agents for T2DM** or the “right insulin at the right time and at the right dose” are tools that could be used to achieve this indicator.
4. Care plans (extended/abbreviated versions) should be provided to patients based on the “responsible prescribing messages” see toolkit. These are on your Practice system for use.
5. Practices will be required to participate in a Practice-based education/patient review program with a local secondary care consultant. To book a practice based diabetes session contact: Andrea.Cronin@haringeyccg.nhs.uk

### Measure of achievement is reported by:

a. Completing, by 30 April 2018, the **Diabetes Action Log and Outcomes Summary** which summarises the patients reviewed outcomes and the prescribing changes implemented.

b. Provision, by 30 April 2018, of a record of the Practice-based educational/patient review session.

### References:


4) Insulin for Adults with Type 2 Diabetes [http://gp.haringeyccg.nhs.uk/downloads/medicines/prescribing/Endocrine/insulin_for_adults_with_type_2_diabetes_v1.0.pdf](http://gp.haringeyccg.nhs.uk/downloads/medicines/prescribing/Endocrine/insulin_for_adults_with_type_2_diabetes_v1.0.pdf)
### Description

**A2. Adults with Asthma.**

Practice should:
- have in place a designated, named clinical lead for asthma services
- Use the PRIMIS* asthma audit tool to improve asthma care and meet NRAD recommendations. Tool identifies patients needing review.

### Measure

Number of patients reviewed:
- identified as overusing reliever therapy and underusing ICS to have a clinical review in order to amending repeat ordering quantities
- who have an asthma care plan

**Payment Per Review £40**
Prescribing adviser assistance (£20)

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**Aim**

To optimise and improve the management of adult patients with asthma, to improve asthma care and meet NRAD recommendations.

**Background**

Asthma is a complex disease that for most patients can be successfully managed. It is characterised by episodes of expiratory airflow obstruction which occur in response to multiple stimuli. The frequency and severity of these episodes varies greatly, both between and within individuals. Since all individuals with asthma are susceptible to exacerbations of asthma, it follows that all those with diagnosed asthma need to know how to manage these episodes. This instruction in self-management can be formalised as a written action plan, and all asthmatics are candidates for such a plan.¹

Assessment of asthma control is already undertaken as part of standard care under QOF indicator Asthma 6. This indicator requires the use of the PRIMIS* ASTHMA tool to reinforce good practice. The tool enables GP practices to audit their clinical data so as to optimise the management and care of patients with active asthma and reduce their risk of exacerbation and hospital admission.²

The first National Review of Asthma Deaths by The Royal College of Physicians was published in May 2014. The report analysed data for 195 people thought to have died from asthma between February 2012 and January 2013 to establish the circumstances of the death and what factors could have been addressed in order to prevent it. The report issues a number of recommendations to help prevent similar deaths in the future.² This indicator will focus on the recommendation that patients with excessive use of reliever and under use of preventer medication should be called in for a review and counselling. The PRIMIS tool will help identify these patients.

**How to achieve indicator:**

The team will be using the PRIMIS Asthma Care tool, which enables GP practices to audit their clinical data so as to optimise the management and care of patients with active asthma and reduce their risk of exacerbation and hospital admission.⁵

1. Practices to register at PRIMIS Hub for access PRIMIS Asthma tool and agree to a PRIMIS Practice Agreement for remote access with the help of prescribing advisors (PA), if not already done so.
2. Practices need to nominate an Asthma lead who will oversee this completion of this audit as well as the "named person" to access Asthma tool via PRIMIS* website.
3. PA’s will run PRIMIS Asthma software in practice and extract a patient list that identifies all Asthma patients on practices register according to target areas.
4. This will be classed as the baseline report.
5. Baseline and end of year reports will be run and provided as their results give the practice an overview of current Asthma management.
6. Practices to review provided extracted baseline patient list in accordance with set targets to be achieved listed below:
   - Number of patients reviewed who have had a review and provided an asthma care plan
7. For patients requiring a review, employ motivational interviewing techniques (see MI tool kit), to obtain best outcomes for them.

8. Practices to ensure healthcare professionals who review inhaler therapy are able to demonstrate device techniques correctly and clearly to the patient and/or carers.
   - Refer to RightBreathe tool for inhaler technique demonstrations and recommended choice of inhalers [https://www.rightbreathe.com/](https://www.rightbreathe.com/)

**Measure of achievement is reported by:**
Submission of audit by 30th April 2018, which summarises the practice action plan for patients reviewed with outcomes and the prescribing changes implemented.

**References:**
1. [http://thorax.bmj.com/content/thoraxjnl/59/2/94.full.pdf](http://thorax.bmj.com/content/thoraxjnl/59/2/94.full.pdf)

### Description and Measure

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure</th>
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<tbody>
<tr>
<td><strong>A3. Atrial Fibrillation (AF):</strong> Review a list of patients provided by secondary care that have been identified as possibly suffering with atrial fibrillation that are not on the Practice Quality Outcomes Framework (QOF) atrial fibrillation register. Clinicians are asked to review diagnosis and assess for anticoagulation.</td>
<td>Number of patients reviewed with diagnosis confirmed. All suitable patients referred for anticoagulation.</td>
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**Background**

Haringey’s reported AF prevalence is lower than most similar boroughs and much lower than the England Average. Fig 1.

This Quality indicator will help bring Haringey’s prevalence closer to national levels and has the potential to save many lives and translate into cost savings. “Treating patients with an anticoagulant could prevent 6,000 strokes nationally and save 4,000 lives each year” (NICE 2006). This indicator will be monitored by measuring the increase in number of patients on an anticoagulant per practice.

**How to achieve indicator:**
A list of patients identified through data extraction as being coded for AF in secondary care but missing from practice QOF data will be sent to Practices. Practices will be expected to review patient record and:
1. Invite appropriate patients for a review
2. Use the AliveCor® device to confirm the presence of AF
3. If result in 2 above is positive then consider anticoagulation for men with a CHA₂DS₂-VASc score of 1 and offer anticoagulation for all patients with CHA₂DS₂-VASc score >2 or above. Referral form [LINK]
4. Discuss benefits Vs risks for anticoagulation and consider any contraindications, use the dispelling myths around AF to help the patient understand the disease and why they should opt for treatment. Dispelling Myths sheet located in the Motivational Interviewing toolkit.
5. If bleeding is a risk this should be reassessed using HAS-BLED scores which predicts risk of bleeding tool also on referral form
6. Re-discuss anticoagulation with patient if previously refused.

**Measure of achievement is reported by:**
Submission of results, by 30 April 2018, showing number of patients reviewed, number of patients with a confirmed diagnosis and all suitable patients referred for anticoagulation.

**References:**
1) Atrial Fibrillation: The management of atrial fibrillation- NICE CG 36, 2006
2) Impact of the CHA₂DS₂-VASc Score on Anticoagulation Recommendations for Atrial Fibrillation. P. K. Mason et al The American Journal of Medicine, Vol 125, No 6, June 2012

<table>
<thead>
<tr>
<th>Option</th>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td><strong>A4. COPD</strong></td>
<td><strong>Use a PRIMIS search tool to interrogate clinical data, enabling the improvement of patient outcomes, reducing costs and avoiding inappropriate treatment for patients with COPD. Tool will identify patients to review.</strong></td>
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<tr>
<td></td>
<td><strong>Report results from the following-</strong></td>
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<tr>
<td></td>
<td><strong>Review patients on therapy that is not supported by evidence:</strong></td>
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<tr>
<td></td>
<td>○ Patients with no inhalers recorded who have an FEV1&lt;50%.</td>
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<tr>
<td></td>
<td>○ Patients on triple therapy with FEV1 &gt;50%</td>
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<td></td>
<td><strong>Ensure each patient is offered:</strong></td>
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<tr>
<td></td>
<td>○ a flu vaccination</td>
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<td></td>
<td>○ inhaler technique check</td>
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<td></td>
<td>○ very brief smoking cessation advice</td>
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<td></td>
<td><strong>Payment Per Review £50</strong></td>
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<td></td>
<td><strong>Prescribing adviser assistance (£25)</strong></td>
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**Aim**
To improve overall Chronic Obstructive Pulmonary Disease (COPD) management enabling better patient outcomes, reduce costs and avoid inappropriate treatment for patients.

**Fig 1** shows that flu vaccination, smoking cessation support and pulmonary rehabilitation are cost effective alternatives to drug treatment in the management of COPD. Triple therapy (LAMA+LABA+ICS) has been shown to be effective in some patients with severe disease, but in many pharmacoeconomic analyses, the cost per QALY gained is very high. These estimates are in the appendix of the NICE COPD guidelines.

**Background**
The management of patients with stable COPD is aimed at control of symptoms, prevention of exacerbations and improvement in exercise capacity. COPD exacerbations account for 10% of all medical admissions. Frequent exacerbations of COPD cause further lung function decline and increase morbidity and mortality. Non-adherence is estimated at between 30–70%; up to 50% may be deliberate and 30% or more may be on suboptimal therapy for the severity of their disease. Non-adherence can lead to over-ordering and wasteful use of NHS resources. In 2015 the top 10 leading cost drugs, nationally, included inhalers.
The burden of the disease is such that amongst patients hospitalised for COPD, 50% are subsequently re-admitted. Every admission prevented could save an average of £1960 (NICE costing template). The direct NHS cost of treating COPD and exacerbations is over £800 million each year. The benefits of primary care intervention for COPD, can best be explained by the COPD value pyramid, which shows that the treatment options for COPD are better the lower down the pyramid you go (see above). This indicator focuses on interventions that produce maximum outcomes for patients.

- Non drug treatments are far more cost effective interventions than inhaled therapy
- Ensuring these non-drug treatments measures in place will ultimately reduce prescribing
- Triple therapy in COPD is not cost effective

**How to achieve indicator:**

1. Practices to register at PRIMIS Hub for access GRASP COPD tool and agree to a “PRIMIS Practice Agreement” for remote access for Haringey prescribing advisors, if not already done so.

2. Practices need to nominate a COPD lead as well as the “named person” to access GRASP COPD tool via PRIMIS* and lead on the audit.

3. Prescribing Advisors will run the GRASP_COPD software in practices and create patient list that identifies all COPD patients and their corresponding intervention achievements. This will serve as the baseline for the audit.

4. Review patients on therapy that is not supported by evidence:
   - Patients with no inhalers recorded who have an FEV1<50%
   - Patients on triple therapy with FEV1 >50%

   Use Motivational Interviewing techniques to offer patient (see MI toolkit):
   - a flu vaccination
   - inhaler technique check
   - very brief smoking cessation advice

5. Practices to ensure healthcare professionals who review inhaler therapy are able to demonstrate device techniques correctly and clearly to the patient and/or carers
   - Refer to RightBreathe tool for inhaler technique demonstrations and recommended choice of inhalers [https://www.rightbreathe.com/](https://www.rightbreathe.com/)

*(PRIMIS is a business unit of The University of Nottingham that extracts, collects, analyses, provides clinical data display, presentation and interprets the clinical data from the GRASP COPD tool)*

**Measure of achievement is reported by:**
Submission of anonymised list of patients reviewed and the outcome of the reviews.

**References:**

2) NICE. Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care. NICE, 2010
3) NICE. Quality Standard for Chronic Obstructive Pulmonary Disease. July 2011
Section B (all Practices)

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure</th>
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<tbody>
<tr>
<td>Working with prescribing advisers</td>
<td>Evidence that GPs have worked collaboratively with prescribing advisers</td>
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</table>

**Aim**
Prescribing advisers to assist practices to raise the quality, safety and cost effectiveness of medicine use.

**Background**
For the past 4 years, the MMT has worked closely with Practices to identify areas where prescribing quality, safety and cost effectiveness could be raised.

Medicines optimisation has become increasingly more demanding over the years and involves a more complex approach as we move into the patient centred approach of involving people in decisions about their care. The Prescribing Advisors' role will be to release GPs from delivering elements of the PQSS, reduce medicines wastage and overuse, and overall, improve patient safety regarding use of their medicines. The increased presence of pharmacists has proved popular with GPs leaving GPs more time to get on with other activities. The prescribing advisers increased presence has also consolidated relations between the MMT and practices as GPs are more readily available to answer queries on a face to face basis.

**How to achieve indicator:**
Practices will achieve the indicator by working collaboratively with prescribing advisers. Prescribing advisers will review Practices’ prescribing, identify outlier areas and make recommendations to the Practice on where they could work jointly. Areas to be covered could include but are not restricted to:

- General prescribing issues
- Installation of a formulary on Practice systems to aid the choice of cost effective medicines.

**Examples of QIPP areas**
Increase standard release quetiapine and low cost quetiapine MR as a % of all quetiapine MR
Increase low cost opioid patches as a % of all opioid patches.
Increase generic latanoprost (including combinations) as a % of prostaglandin eye drops.
Increase preferred powdered ONS as a % of all sip feeds.
Decrease infant feeds cost per 1,000 patients UNDER 5 (excl. tube & sip).
Decrease doxazosin MR, prescribe standard release.

Any other area identified by the prescribing adviser and/or MMT.

**Measure of achievement is reported by:**
Evidence of working cooperatively with prescribing advisers in identified areas.
Section C (for Practices not completing Section D)

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure</th>
</tr>
</thead>
</table>
| **C1. Repeat Prescribing**  
  • Review 2016/17 repeat prescribing audit and implement action plan  
  • Engage in activities to reduce patient over ordering of medicines e.g. using of posters and leaflets  
  • Appoint a practice medicines co-ordinator (PMC) to lead on repeat prescribing and to complete an e-learning package |  
  • Evidence that action plan has been implemented  
  • 10% of patients are ordering repeat prescriptions on-line by March 2018  
  • PMC appointed and evidence that e-learning completed |

**Aim**
To have a safe and efficient process for managing repeat prescribing.

**Background**
Prescribing is the most common patient-level intervention and it is the second highest area of spending in the NHS. Repeat prescriptions represent approximately 60-75% of all prescriptions written by GPs and approximately 80% of primary care prescribing costs.

The volume of repeat prescribing in general practice results in a vast amount of work and a source of potential risk to patient safety. Improving repeat prescribing systems is to everyone’s benefit; it can save time for patients and clinicians, whilst improving follow up and safety.

Repeat prescribing can be managed in a number of ways e.g. using repeat dispensing, electronic prescribing and managed repeat prescription services offered by community pharmacies. It is essential that practices have a repeat prescribing system underpinned by a robust policy to ensure repeat prescription requests are dealt with efficiently and safely.

The repeat prescribing audit carried out in Haringey practices in 2016/17 identified the following:

- patients over ordered medicines by 0% to 22% (average 12%)
- pharmacists over ordered 7% to 52% (average 21%)

This high percentage of wastage needs to be reduced.

**How to achieve this indicator:**
Practices must appoint a Practice Medicines Co-ordinator (PMC) who will access and complete an e-learning package or all Practice staff involved in repeat prescribing to attend a workshop run by the MMT and audit change in practice.

Practices must also increase the proportion of prescriptions directly ordered by patients by offering online prescription ordering and engaging in patient publicity activities to reduce over ordering of medicines e.g. using posters and leaflets “Hand back unneeded medicines while you are in the pharmacy”.

**Measure of achievement is reported by:**
Send the completed record of actions to the MMT by 30 April 2018.
**Aim**

Currently around 20% of GP time and 40% of their total consultations are used for minor ailments and common conditions at an estimated cost of £2 billion per year to the NHS.¹ Increased life expectancy, greater public expectation, greater public awareness and patients becoming more health focused have led to an increased demand on GPs. So that GPs can spend more time treating patients with complex health problems and long term chronic illnesses, it is important that patients are encouraged and empowered to self-care for minor ailments and common conditions with over-the-counter medications (OTC).¹²

**Background**

There is growing evidence to show that supporting self-care improves symptom management, general health, quality of life and patient satisfaction.³ Additionally self-care impacts the use of services by decreasing primary care consultations, visits to outpatients, A&E attendances, use of hospital resources and admittance in to secondary care.³ Viral infections and hay fever are the most common minor ailments seen by doctor.⁴ Both of these common conditions could be suitable for treatment with over the counter medication.

**How to Achieve Indicator:**

1. Use the CCG guidance and resources to support and implement self-care and publicity campaigns.
2. Encourage and empower patients to be responsible for their own health and well-being. Make patients aware that the GP might not issue a prescription for OTC treatments. Patients do not have to go through the process of booking an appointment with their GP and getting a prescription, when they could [can] go straight to a pharmacy and receive their treatment straight away.
3. Encourage people to keep a small stock of essential medications at home to treat minor ailments and common conditions. A poster is available here.
4. Ensure patients are made aware of warning signs or symptoms which would require them to see their GP.
5. Reduce or maintain a quarterly spend on self-care medicines to below £520 per 1,000 patients.
Measure of achievement is reported by:
Quarterly spend on self-care medicines is reduced to below £520 per 1,000 patients.

References:

Description Measure

| C3. Prescribing of Hypnotics: | Review patients on hypnotics and consider dose reduction, stopping or change in hypnotic Toolkit to be completed and results submitted. Target: 45% of patients reviewed either stop hypnotic, reduce dose or change to an alternative that supports dose reduction. |

Aim
- To review patients on hypnotics and wherever possible, reduce or stop prescribing in line with best practice.
- Where this action is not clinically appropriate, employ dose optimisation, or the use of a more cost effective alternative such as zopiclone.

Background
Insomnia is a disturbance of normal sleep patterns commonly characterised by difficulty in initiating sleep (sleep onset latency) and/or difficulty maintaining sleep (sleep maintenance).

The NICE Clinical Knowledge Summary (CKS) on managing insomnia advises initial exploration of a non-drug therapy. This includes advice on bedtime routine and relaxation techniques.

Though the CKS notes there is insufficient evidence to assess the effectiveness of sleep hygiene as a single intervention, its use is widely supported by expert opinion in current literature and guidelines.

If non-drug measures have failed and the patient’s insomnia is severe, disabling or causing extreme distress, hypnotic therapy may be used. Hypnotic therapy should then be prescribed for short periods of time only, in strict accordance with the licensed indications.

The term hypnotic refers to short acting benzodiazepines (temazepam, loprazolam, lormetazepam) and the Z-drugs (zopiclone, zolpidem, and zaleplon (now discontinued)). This would be for no more than four weeks with benzodiazepines, or two to four weeks with Z-drugs.

The British National Formulary (BNF) states that benzodiazepines and the Z–drugs should be avoided in the elderly, because the elderly are at greater risk of becoming ataxic and confused, leading to falls and injury. Where a hypnotic is used for short term use, it should not be given for more than three weeks (preferably only one week). Intermittent use is desirable with omission of some doses. A short acting drug is usually appropriate. Risks associated with long term hypnotic include falls, accidents, cognitive impairment, dependence and withdrawal symptoms.

As part of the PQSS for 2015/16, practices were asked to review patients on Temazepam and consider dose reduction, stopping or change in hypnotic. This resulted in the medication of 21% (48 patients) of patients being stopped and 26% (59 patients) switched to another hypnotic (zopiclone). As a result of this success, the medicines optimisation committee (MOC) agreed the need to extend the audit to all hypnotics.
How to achieve indicator:
- Run a search for patients taking a hypnotic.
- Decide which patients should be considered for a reduction, stop or change in agent (such as generic zopiclone) following a careful, individual clinical risk-benefit analysis.
- For those patients who do not qualify for the above but are taking multiple doses, optimise where possible e.g. 2 x10mg of temazepam changed to 1 x 20mg.

Measure of achievement is reported by:
Send a summary of your intervention, (completed toolkit and results) to the MMT by the 30 April 2018. See toolkit for information to be sent. 45% of patients reviewed to either stop, reduce dose or change to an alternative dose of hypnotic that supports dose reduction.

References:

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C4. Reducing Acute Kidney Injury (AKI)</strong></td>
<td>Anonymised risk register</td>
</tr>
<tr>
<td>1. Use a search tool to identify patients who</td>
<td>Number of patients reviewed and submission</td>
</tr>
<tr>
<td>have had an episode of AKI in the preceding 12</td>
<td>of review results</td>
</tr>
<tr>
<td>months, create and maintain an at risk register</td>
<td></td>
</tr>
<tr>
<td>2. Complete a medication review</td>
<td></td>
</tr>
<tr>
<td>3. Educate the patient and/or carer about risk</td>
<td></td>
</tr>
<tr>
<td>of dehydration during acute illness and when</td>
<td></td>
</tr>
<tr>
<td>to seek help/advice</td>
<td></td>
</tr>
</tbody>
</table>

**Aim**
- To establish and maintain a register of all people aged 18 years and over with an episode of AKI in the preceding 12 months
- To review the medication of the patients identified in order to minimise the risks of a future episodes
- To increase awareness in ‘at risk’ patients by educating and promoting self-care such as to avoid preventable factors that can lead to AKI

**Background**
Acute kidney injury, previously known as acute renal failure, is a sudden loss of kidney function that can be caused by preventable factors such as dehydration due to diarrhoea, vomiting, blood loss or drug therapy. In England over half a million people develop AKI every year and it is estimated that one in five people admitted to the hospital each year as an emergency has AKI. In the UK up to 100,000 deaths each year in hospital are associated with AKI, up to 30% could be prevented with the right care and treatment. The costs to the NHS of AKI (excluding costs in the community) are estimated to be between £434 million and £620 million per year, which is more than the costs associated with breast cancer or lung and skin cancer combined.

NHS Improvement have recently issued a patient safety alert to continue to raise awareness of AKI and to signpost clinicians from all care settings, including GPs and community pharmacists, to a set of resources developed by “Think Kidneys” (a three year national AKI prevention programme established in partnership with NHS England and the UK Renal Registry). AKI is increasingly being seen in primary care in people without any acute illness, and awareness of the condition needs to be raised among primary care health professionals.

Many medications are cleared via the kidneys, so have the potential to accumulate during an episode of AKI. The result of this may be a further deterioration in kidney function, or there may be other adverse effects. Older patients with chronic (long-term) medical conditions e.g. chronic kidney disease, diabetes mellitus, heart failure, cancer, and medications are at increased risk of AKI if they become acutely ill. Hence it is necessary to review the use of these nephrotoxic medications and amend the doses appropriate to the level of the patient’s renal function.
How to achieve indicator:
1. Run a search to identify patients that have had an episode of AKI in the preceding 12 months.
2. Use the above to establish and maintain a register of all patients aged 18 years and over with an episode of AKI in the preceding 12 months.
3. Review the resulting list according to a set criteria laid out in the toolkit.
4. Provide sick day advice and education around AKI to patients and/or carers.
5. A member of Practice to attend an educational event on kidney disease.

Measure of achievement is reported by:
Have an anonymised risk register. Submit to the MMC by 30 April 2018 the number of patients reviewed, and results of review. Provide evidence that a member of the Practice has attended an educational event on kidney disease.

NB: Contact secondary care Heart Failure nurse to discuss around stopping ACE I/ARB/ Diuretics in patients with HF

References:
3. Think kidneys: Acute Kidney Injury - The NHS campaign to improve the care of people at risk of, or with, acute kidney injury https://www.thinkkidneys.nhs.uk/aki/

Section D: ONLY Practices supporting care homes and practice where repeat prescribing audit has identified high levels of waste should focus on one of these areas

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure</th>
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</table>
| **D1. Care Homes Prescribing Review**                                      | Audit report In line with: https://www.nice.org.uk/guidance/sc1/ftp/chapter/Prescribing-medicines-for-people-in-care-homes and "Developing a prescribing protocol guidance for GP practices (Health and Social Care Board, May 2016)"

Aim
To ensure Practices follow good practice for managing medicines in care homes to whom they provide services. The good practice should be in the form of a guide that promotes the safe and
effective use of medicines in care homes by advising on processes for prescribing, handling and administering medicines.

**Background**

At least 25% of people over 60 years old have two or more long term conditions which means that there are a number of patients in care homes on a number of medicines\(^1\). Such multiple medicines usage (polypharmacy) is driven by an ageing, increasingly frail and multimorbid population. Though in some patients it may be clinically appropriate, it can increase clinical workload and clinical complexity. Polypharmacy can also be problematic, where multiple medicines are prescribed inappropriately or where the intended benefit of the medicine is not realised.

Furthermore harm associated with polypharmacy include increased risk of medicine related errors which include prescribing, monitoring, dispensing and administration errors. This can then further result in adverse drug reactions, impaired medicines adherence and compromised quality of life for patients. Avoidable financial costs arises not only in terms of morbidity and mortality but also of medicine waste and additional resources on health services.

NICE Managing medicines in care homes (SC1 - March 2014) states\(^2\) ‘...GP practices should have a written process for prescribing and issuing prescriptions to their patients who live in care homes. All medicines prescribed should be recorded in the person's GP patient medical record and their care record. Records are likely to include instructions on how to use the medicine (for example, where to apply a cream and how much to use), how long the medicine should be used, how long the medicine will take to work and what it is for....’

**How to achieve indicator:**

Practices should ensure that there is a clear written process for prescribing and issuing prescriptions for their patients who live in care homes in line with NICE Managing medicines in care homes (SC1 - March 2014). Upon preparation it should be agreed for implementation and reviewed periodically as applicable.

The process should cover but not limited to:

- issuing prescriptions according to the patient medical records
- recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and what it has been prescribed for (use of the term ‘as directed’ should be avoided)
- recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible
- providing any extra details the resident and/or care home staff may need about how the medicine should be taken
- any tests needed for monitoring
- prescribing the right amount of medicines to fit into the 28-day supply cycle if appropriate, and any changes that may be needed for prescribing in the future
- monitoring and reviewing ‘when required’ and variable dose medicines
- issuing prescriptions when the medicines order is received from the care home

**Measure of achievement is reported by:**

Practices need to submit to the MMT by 30 April 2018 a summary of both the written process together with agreed implementation plan.

**References:**


2) NICE Managing medicines in care homes (March 2014) [https://www.nice.org.uk/guidance/sc1](https://www.nice.org.uk/guidance/sc1)
### Description

**D2. Repeat Prescribing (Part B) For Practices with High Levels of Over Ordering of Repeat Medicines**

- Review 2016/17 repeat prescribing audit and implement action plan
- Engage in activities to reduce patient over ordering of medicines e.g. using of posters and leaflets
- Appoint a practice medicines co-ordinator (PMC) to lead on repeat prescribing and to complete an e-learning package

<table>
<thead>
<tr>
<th>Measure</th>
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<tbody>
<tr>
<td>- A 5% reduction in over ordering</td>
</tr>
<tr>
<td>- 30% increase in patients ordering their own repeat medicines</td>
</tr>
<tr>
<td>- 50% patients requesting repeat prescriptions online by March 2018</td>
</tr>
<tr>
<td>- PMC appointed and evidence that e-learning completed</td>
</tr>
</tbody>
</table>

### Aim

To have a safe and efficient process for managing repeat prescribing and to reduce over ordering. This will be supported by a Medicines Optimisation pharmacist working with the practice.

### Background

Prescribing is the most common patient-level intervention and it is the second highest area of spending in the NHS. Repeat prescriptions represent approximately 60-75% of all prescriptions written by GPs and approximately 80% of primary care prescribing costs.

The volume of repeat prescribing in general practice results in a vast amount of work and a source of potential risk to patient safety. Improving repeat prescribing systems is to everyone’s benefit; it can save time for patients and clinicians, whilst improving follow up and safety.

Repeat prescribing can be managed in a number of ways e.g. using repeat dispensing, electronic prescribing and managed repeat prescription services offered by community pharmacies. It is essential that practices have a repeat prescribing system underpinned by a robust policy to ensure repeat prescription requests are dealt with efficiently and safely.

The repeat prescribing audit carried out in Haringey Practices in 2016/17 identified the following:

- patients over ordered medicines by 0% to 22% (average 12%)
- pharmacists over ordered 7% to 52% (average 21%).

This high percentage of wastage needs to be reduced.

### How to achieve this indicator:

Practices must appoint a Practice Medicines Co-ordinator (PMC) who will access and complete an e-learning package or all Practice staff involved in repeat prescribing to attend workshop run by the MMT and audit change practice.

The Practice should achieve a 5% reduction in over ordering from 2016/17 audit report, a 30% increase in patients ordering their own repeat medicines and 50% of patients requesting repeat prescriptions through online ordering.

Practices must also increase the proportion of prescriptions directly ordered by patients by offering online prescription ordering and engaging in patient publicity activities to reduce over ordering of medicines e.g. using posters and leaflets “Hand back unneeded medicines while you are in the pharmacy”.

### Measure of achievement is reported by:

Practices need to submit to the MMT by 30 April 2018 evidence of 5% reduction in over ordering from 2016/17 audit report, a 30% increase in patients ordering their own repeat medicines and 50% of patients requesting repeat prescriptions through online ordering, and evidence that a PMC has been appointed and that e-learning has been completed.
1. **Monitoring of the Scheme**
   - Prescribing expenditure is monitored from April 2017 to March 20178
   - Prescribing performance for April 2017 to March 2018 will be used to monitor performance against the antibiotic entry criteria
   - Practices will be monitored for participation in the NDA following the HSCIC invitation to participate monitoring period will be during the month of June 2017

2. **Payment of the Scheme**
   - **Genuine unforeseen changes** in practice structure (e.g. list size increase, expensive patients) will be acknowledged when reviewing performance against allocation and prescribing targets. Practices that do not meet the financial aspects of the entry criteria despite best endeavours or due to special circumstances, may receive an appropriate payment.
   - **Practices overspending** their budget but reducing their overspend may receive a payment
   - The CCG reserves the right to withhold payment under the incentive scheme, if savings have been made by "windfall" changes (e.g. loss of high cost patient, list size reduction and category M price changes) or withholding treatment to their patients
   - If the level of payments exceeds the available resources (currently £315,000) the level of payments will need to be scaled down proportionately
   - Decisions on the above will rest with the Medicines Optimisation Committee
   - New partnerships taking over a practice in year may receive incentive payments pro-rata

3. **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 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.

4. **Incentive Payments**
   Practices must achieve savings on their prescribing budget to qualify for reward payments for sections B, C and D. These targets in total will amount up to 40% of the practices savings depending on the option chosen.

   30% of the £315,000 PQSS budget (£94,500) is ring fenced for Section A. Practices will be paid in the region of £12.50 to £50 per patient reviewed depending on the option chosen.

   Practices will be assessed on the targets achieved, attendance at educational meetings and submission of reports/audits.

5. **Method of Payment**
   Analysis of achievement and savings will be completed in July/August 2018 and practices will be notified of awards achieved.

   Following notification, Practices should submit a plan of how they intend to spend the whole of their incentive payment for the benefit of patient care. For audit purposes, Practices must keep written records of expenditure.

   Following receipt of plan and approval, payment will be paid directly into Practice funds and not to individuals.

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**Appendix 1**

**Monitoring of and Payment of the Scheme**

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NB: Payments cannot be made for retrospective purchases/ expenditure.

CRITERIA FOR PRACTICE SPENDING OF PQSS AWARDS

Practices must use the savings for direct improvement of patient facilities and services.

Examples of spending that would be approved are:

1. A new clinic/service with specific patient criteria where additional staff and /or equipment is required above what the Practice is already contracted to provide e.g. Employing a Clinical Pharmacist, Paediatric Specialist; Gym Club trainer for patients; or additional clinics for health promotion.

2. New equipment that will enhance clinical services – items such as spirometers, oximeters, mobile ECG machine, CO monitors, near patient testing (CRP) and foetal heart monitors.

3. Improvements to clinical areas to meet latest guidance in respect of Health and Safety, DDA and Infection Control. This may include replacement flooring, sinks, fire extinguishers, defibrillators and patient seating and couches, emergency medication storage box with alarm, lockable cabinet for prescriptions.

4. Improvement to patient waiting areas and toilet facilities to meet H&S, DDA, IC and FS guidance, such as replacing carpets with hard, water resistant flooring, purchasing new seating and information displays, deep cleaning, self-check in kiosk, improving practice signage, improvement of wheelchair access, non-slip resurfacing and automatic front door.

5. Training - for clinical and administration development above standard required to perform role. This is where training enhances knowledge to improve services and may include diplomas, degrees and specialist courses.

6. Equipment to enhance patient administration services such as Jayex boards, patient self-check in and hand held note systems.

7. The purchase of material or equipment which will improve the comfort or convenience of patients of members of the practice including furniture, furnishings, security features, heating/air conditioning or vending machines for the practice.

8. Initiatives to improve prescribing.

9. The purchase of material or equipment relating to health education including television, videos, leaflets, leaflet holders, A3 laminator and posters and payment for advice on how best to disseminate health education advice to patient.

10. Other: Auto-voice text to speech to support outbound calls outbound from the practice telephone lines, hardware and software to support IT developments not funded elsewhere e.g. Vision Anywhere, away from my desk to access EMIS at home, eConsult.

Examples of spending that would not be approved are:


2. Routine Practice equipment such as stethoscopes, adult scales, BP monitors, disposables etc. This includes equipment for additional and enhanced services that the practice is contracted to provide. Wall Mounted Couch Roll Dispenser, Mobile screen, Thermometer, Height measure (portable), Tuning Fork.
3. Staff hours that are not additional to normal paid hours. This includes situations where staff are allocated to new projects but their hours are not increased and funding for locums.

4. General staff away days.

5. Improvements to staff only areas such as kitchens, offices, car parks and meeting rooms.

6. General office equipment such as computers, scanners and printers, repairs and consumables.

The above lists are not exhaustive - we will consider all proposals that meet the general criteria.

Appendix 2

Guide to Prescribing Analysis Terms

Denominators provide a method of comparing behaviour between different groups of prescribers. The various denominators have developed over time as knowledge of what affects prescribing patterns is gained or the ability to manipulate the information is available.

(a) PUs - Prescribing Units

In an attempt to make comparisons between practices, a more valid weighting factor called the prescribing unit was introduced in England in 1983 to take account of the greater health needs of elderly patients. Patients aged 65 or over count as three prescribing units. Patients under 65 years of age and temporary residents count as one prescribing unit.

(b) ASTRO-PUs - Age, sex and (temporary resident) originated prescribing units

Derived by the National Prescribing Research Unit in 1993. ASTRO-PUs were designed to weight practice populations for age, sex and temporary residents rather than just the number of patients aged 65 and over as in the PU weight system. In light of further research the weightings of the age bands were adjusted in 2013. Temporary resident data is now not collected as practices are reimbursed by a different method and so there is no weighting for temporary residents.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>5-14</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>15-24</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td>25-34</td>
<td>1.3</td>
<td>1.8</td>
</tr>
<tr>
<td>35-44</td>
<td>1.8</td>
<td>2.6</td>
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<tr>
<td>45-54</td>
<td>3.1</td>
<td>3.7</td>
</tr>
<tr>
<td>55-64</td>
<td>5.3</td>
<td>5.4</td>
</tr>
<tr>
<td>65-74</td>
<td>8.7</td>
<td>7.6</td>
</tr>
<tr>
<td>75+</td>
<td>11.3</td>
<td>9.9</td>
</tr>
</tbody>
</table>
### Appendix 3

**Specialist High Cost Drugs**
A separate budget is assigned to practices for these drugs. Practices generally have no control over spend in this area and are thus not penalised. It includes **Percutaneous Endoscopic Gastrostomy feeds**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Name</th>
<th>Drug Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosentan</td>
<td>Lamivudine</td>
<td>Ciclosporin</td>
</tr>
<tr>
<td>Certoparin Sod Sodium</td>
<td>Stavudine</td>
<td>Tacrolimus</td>
</tr>
<tr>
<td>Omalizumab</td>
<td>Zalcitabine</td>
<td>Sirolimus</td>
</tr>
<tr>
<td>Dornase Alfa</td>
<td>Zidovudine</td>
<td>Rituximab</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Valganciclovir Hydrochloride</td>
<td>Peginterferon Alpha</td>
</tr>
<tr>
<td>Tropisetron</td>
<td>Ganciclovir</td>
<td>Interferon Alpha</td>
</tr>
<tr>
<td>Apomorphine Hydrochloride</td>
<td>Adefovir Dipivoxil</td>
<td>Interferon Beta</td>
</tr>
<tr>
<td>Riluzole</td>
<td>Entecavir</td>
<td>Glatiramer Acetate</td>
</tr>
<tr>
<td>Meropenem</td>
<td>Palivizumab</td>
<td>Fulvestrant</td>
</tr>
<tr>
<td>Aztreonam</td>
<td>Cyproterone Acetate</td>
<td>Bicalutamide</td>
</tr>
<tr>
<td>Ertapenem Sodium</td>
<td>Chorionic Gonadotrophin</td>
<td>Buserelin</td>
</tr>
<tr>
<td>Aztreonam With Sodium Chloride</td>
<td>Folitropin Alfa</td>
<td>Cyproterone Acetate</td>
</tr>
<tr>
<td>Ceftazidime Pentahydrate</td>
<td>Folitropin Beta</td>
<td>Goserelin Acetate</td>
</tr>
<tr>
<td>Ceftazidime With Sodium Chloride</td>
<td>Urofollitropin</td>
<td>Leuprorelin Acetate</td>
</tr>
<tr>
<td>Tobramycin</td>
<td>Menotrophin</td>
<td>Triptorelin Acetate</td>
</tr>
<tr>
<td>Linezolid</td>
<td>Somatropin</td>
<td>Octreotide Acetate</td>
</tr>
<tr>
<td>Thalidomide (Antileprotic)_Cap 50mg</td>
<td>Pegvisomant</td>
<td>Lanreotide</td>
</tr>
<tr>
<td>Voriconazole</td>
<td>Buserelin</td>
<td>Epoetin Alfa</td>
</tr>
<tr>
<td>Posaconazole</td>
<td>Nafarelin Acetate</td>
<td>Epoetin Beta</td>
</tr>
<tr>
<td>Lamivudine &amp; Zidovudine</td>
<td>Imatinib Mesilate</td>
<td>Deferiprone</td>
</tr>
<tr>
<td>Darunavir</td>
<td>Bexarotene</td>
<td>Darbepoetin Alfa</td>
</tr>
<tr>
<td>Abacavir</td>
<td>Erlotinib</td>
<td>Deferasirox</td>
</tr>
<tr>
<td>Abacavir/Lamivudine/Zidovudine</td>
<td>Sorafenib</td>
<td>Nitisinone</td>
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<tr>
<td>Tenofovir Disoproxil</td>
<td>Sunitinib</td>
<td>Etanercept</td>
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<td>Amprenavir</td>
<td>Dasatinib</td>
<td>Leflunomide</td>
</tr>
<tr>
<td>Emtricitabine</td>
<td>Nilotinib</td>
<td>Adalimumab</td>
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<tr>
<td>Atazanavir_Cap 300mg</td>
<td>Lapatinib</td>
<td>Infliximab</td>
</tr>
<tr>
<td>Fosamprenavir Calc</td>
<td>Mttotane</td>
<td>Tacrolimus</td>
</tr>
<tr>
<td>Didanosine</td>
<td>Temozolomide</td>
<td>Normal Immunoglobulin (Gamma Globulin)</td>
</tr>
<tr>
<td>Ribavirin (Old)</td>
<td>Mycophenolate Mofetil</td>
<td>Desferriox Mesil_Inj 500mg VI</td>
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