

**REPORT TO THE PRACTICE BASED COMMISSIONING  
GOVERNANCE COMMITTEE**

**TO BE HELD ON: 8<sup>th</sup> July 2009**

<b>Enclosure:</b>							
<b>Subject:</b>	<b>Prescribing Incentive scheme</b>						
<b>Lead Director:</b>	<b>Geraint Griffiths</b>						
<b>Lead Officer:</b>	<b>Linda Smith</b>						
<b>Recommendation:</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><b>For Approval</b></td> <td style="width: 5%; text-align: center;">✓</td> <td style="width: 25%;"><b>For Discussion</b></td> <td style="width: 5%;"></td> <td style="width: 20%;"><b>For Information</b></td> <td style="width: 20%;"></td> </tr> </table>	<b>For Approval</b>	✓	<b>For Discussion</b>		<b>For Information</b>	
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**PURPOSE OF THE REPORT:**

The attached paper sets out a proposal for a Prescribing Incentive Scheme to be used across the Stafford & Surrounds and Cannock Chase Commissioning Consortia. The Scheme aims to reward behaviours that promote both cost and quality improvements.

**KEY POINTS:**

Each consortia will set aside £200k to fund the scheme which will be used as follows

(1) A £20K payment will be available for practices with Antibiotic prescribing below PCT average in Dec 09 qtr OR if at or above PCT average who have achieved a 5% point reduction against PCT average for Dec 08 qtr. This target is a mandatory selection for all practices.

(2) A £100K payment will be available for practices meeting a range of value for money indicators relating to prescribing expenditure against a range of drugs and classes of drug. Practices are required to choose and work on 5 targets. Practices are expected to choose targets they are NOT already achieving as priority and only count targets they are already achieving to make up the 5. All targets are equally weighted.

(3) A further £80K will be awarded for the achievement of the quality improvement targets. Practices are required to choose and work on 4 targets and should give priority to target areas that they are not already achieving.

**IMPLICATIONS:**

<b>Legal and/or Risk</b>	
<b>Standards for Better Health</b>	Promotes delivery of best Practice
<b>Financial</b>	£200k of funds set aside for scheme
<b>Training</b>	
<b>PBC</b>	Scheme developed by PBC and Prescribing Advisor

Other	
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**RECOMMENDATIONS / ACTION REQUIRED:**

The PBC Governance Board is asked to approve the scheme
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## **STAFFORD & SURROUNDS CANNOCK CHASE COMMISIONING CONSORTIUM**

### **Local Enhanced Service for Prescribing & Medicines Management 2009/10**

In March 2009 the number of ASTRO.PU's registered with thirteen Stafford & Surrounds practices was 587,829 (Max award per ASTRO = 34.0235p)

At April 2009 the number of ASTRO.PU's registered with twenty seven Cannock practices was 532,664 (Max award per ASTRO = 37.5471p)

The targets include cost-improvement measures as well as quality improvement topics, not all targets will therefore deliver cost-savings. The proposed awards are therefore to recognise some degree of work needed for achievement, it should be noted however that all the targets are considered good practice, and the awards are not an inducement to prescribe particular drugs.

It proposed that each consortium set aside £200,000 to fund the 2009/10 enhanced service. There are three elements to the scheme:

(1) A £20K payment will be available for practices with Antibiotic prescribing below PCT average in Dec 09 qtr OR if at or above PCT average who have achieved a 5% point reduction against PCT average for Dec 08 qtr. This target is a mandatory selection for all practices.

(2) A £100K payment will be available for practices meeting a range of value for money indicators relating to prescribing expenditure against a range of drugs and classes of drug. Practices are required to choose and work on 5 targets. Practices are expected to choose targets they are NOT already achieving as priority and only count targets they are already achieving to make up the 5. All targets are equally weighted.

(3) A further £80K will be awarded for the achievement of the quality improvement targets. Practices are required to choose and work on 4 targets and should give priority to target areas where they are not already achieving.

Practices are required to commit to the Antibiotic target and 9 other targets by 31<sup>st</sup> July 2009. A copy of this scheme with the targets the practice is planning to work towards indicated by a ✓ in the right hand column should be returned to:

Stafford Practices - Linda Smith, Crooked Bridge Road Stafford  
Cannock practices - TBA

## Targets

Group 1 – Antibiotic Prescribing				
	Target	Notes	%age of scheme	Target Selected
1	The volume/rate of antibiotic prescribing should be no greater than PCT average (Dec 08 = 0.352 items/STAR PU), or a 5% reduction measured against PCT average. (as measured Oct-Dec 09)	Inappropriate antibiotic prescribing contributes to the increase in C-Diff and MRSA infections. GP prescribing of antibiotics in S Staffs is the highest in the WM, and 9% above the national average. Target to be measured using the Health Care Commission	20%	✓

Group 2 – Value for money Indicators				
	Target	Notes	%age of scheme	Target Selected
1	Proportion of “Statin” prescriptions to be prescribed as low-cost “statins” to be no less than 80% of total “statin” prescriptions (or a 10%age point increase from baseline. (achievement as at Mar 10)	The use of low-cost statins is further endorsed by the recent NICE lipid modification guidelines. Potentially many new patients will be identified as a result of national moves to identify primary prevention patients and also from local work to identify patients already disease registers but not picked up by QoF. This should make the 80% target achievable and maintain focus on cost effective statin prescribing. This is a national target.	20%	✓
2	The proportion of ACE inhibitors to be no less than 75% of all ACE + AIIRA (sartan) prescribing. (or a 5%age point increase from baseline) (measured Mar 10)	Whilst cost-saving, this is also a quality measure, ACE inhibitors have superior evidence base in terms of improved outcomes over AIIRA’s. There has been little movement against this target but with many new patients likely to be identified (see above) it is important that practices maintain an ACE first policy. This is now a national performance target	20%	
3	Audit prescribing transdermal analgesic patches used for chronic pain management (Submitted Mar 10)	Transdermal analgesia costs are growing exponentially; there is significant variation between practices- transdermal analgesia should be generally reserved for patients with swallowing difficulties or intolerance issues with oral morphine. Audit to identify patient’s therapy prior to initiation of patch formulation and review appropriateness of use.	20%	

4	For the expenditure on blood glucose test strips not to exceed £73 per cost based endocrine STAR-PU (Measured Jan – Mar 2010 inc)		20%	
5	For 90% of PPI items to be for low-cost generic drugs (lansoprazole & omeprazole caps) or 10% INCREASE FROM BASELINE (Measured Mar 10)	This is now a national performance target	20%	
6	The proportion of low-cost “safe” SSRI’s to be no less than 80% of total. (this includes generic fluoxetine, citalopram and sertraline) (Measured Mar 10)		20%	
7	The proportion of bisphosphonates prescribed as generic Alendronate to be no less than 80% (Measured Mar 10)		20%	

### Group 3 – Quality Improvement

	Target	Notes	%age of scheme	Target Selected ✓
1	Prescriptions for evidence base doses of low cost statins, to be no less than 70% of total. (achievement as at Mar 10)	In terms of improving outcomes- there is strong evidence for doses of 40mg+ for simvastatin and 40mg for pravastatin. There is no outcome data for simvastatin 10mg	20%	
2	Nutritional Food Supplements Audit patients prescribed food supplements, focus on sip-feeds & prescribed foods. Identify patients, review indication and continued need. (audit & results to be submitted by Mar 10)	Prescribing of Nutritional supplements is increasing and evidence from some initial audits indicates monitoring and initial assessment of patient nutrition needs could be improved. Local Guidance has been developed and this provides suitable audit criteria	20%	
3	Audit of High Dose Respiratory Steroid Prescribing in patients with COPD. Aim to establish prescribing is in line with NICE guidance; i.e. for patients with predicted FEV1 =<50% and two or more exacerbations in 12 month period. (audit & results to be submitted by Mar 10)	Initial audit work conducted as part of last years scheme has indicated <ul style="list-style-type: none"> <li>• Few patients have predicted FEV1 recorded (not able to assess compliance with NICE guidance)</li> <li>• Registers show patients as Asthma rather than COPD.</li> </ul> This is a large piece of work and Practices would like to Re –audit this year.	20%	
4	28 – Day prescribing. Practice to increase proportion of Controlled Drug Prescriptions issued as 28/30 days.( or maintain position if already at an acceptable level) Measured on a basket of CDs drugs as this is considered good practice.	All practices are strongly advised to prescribe no more than 28/30 days of Controlled drugs.	20%	

5	To undertake and action an audit of clopidogrel prescribing against NICE guidance. (audit & results to have been submitted by Mar 10)	In ACS the combination of aspirin and clopidogrel should stop after 12 months and the patient maintained on aspirin. Patients considered intolerant of aspirin should meet the NICE defined criteria. If the patient has developed dyspepsia on aspirin, it should be co-prescribed with a low-cost PPI.	20%	
6	A minimum of 50% NSAID items to be prescribed as the safer alternatives of Ibuprofen and naproxen. (measured Mar 10)	Diclofenac has been associated with an increase in cardiovascular risk similar to coxibs. MHRA advice first choice NSAIDs should be Ibuprofen and Naproxen	20%	