

REPORT TO THE PBC GOVERNANCE TO BE HELD ON 9th September 2009

Enclosure:						
Subject:	Seisdon prescribing incentive scheme					
Lead Director:	Geraint Griffiths					
Lead Officer:	Mark Seaton					
Recommendation:	For Approval	<input checked="" type="checkbox"/>	For Discussion	<input type="checkbox"/>	For Information	<input type="checkbox"/>

PURPOSE OF THE REPORT:

This proposal outlines the Seisdon prescribing incentive scheme. The locality is committed to addressing the priority of antibiotic prescribing.

KEY POINTS:

The consortia will set aside £120k to fund the scheme.

Seisdon have adopted the same scheme as Cannock and Stafford. This revised amended scheme was approved by PBC Governance in July.

IMPLICATIONS:

Legal and/or Risk	There are no foreseeable legal implications as this type of scheme is well established.
Standards for Better Health	C4d
Financial	Supports cost reduction and quality improvement in prescribing
Training	none
PBC	
Patient Engagement & Safety	

RECOMMENDATIONS / ACTION REQUIRED:

PBC Governance are asked to approve this proposal

Seisdon Commissioning Consortium

Local Enhanced Service for Prescribing & Medicines Management 2009/10

In March 2009 the number of ASTRO.PU's registered with eight Seisdon practices was 309,771 (Max award per ASTRO = 38.7383p).

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. Whilst this scheme is aimed at resourcing and supporting good practice it does not preclude the right of the PCT to exercise options relating to poor performance in relation to prescribing.

It proposed the consortium sets aside £120,000 to fund the 2009/10 enhanced service.

There are three elements to the scheme:

- (1) Antibiotic prescribing in this locality is causing concern in relation to the incidence of C-Diff cases locally. This is a priority target for the consortium to address during 2009/10. A £24K payment will be shared between each practice with Antibiotic prescribing below National average in Dec 09 qtr OR if at or above National average who have achieved a 5% point reduction against National average for Dec 08 qtr. This target is a qualifying target- all practices must therefore achieve this target before any payments will be made under this scheme.
- (2) A £60K 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 expected to choose and work on up to 5 targets. Practices are required 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 £36K will be awarded for the achievement of the quality improvement targets. Practices are expected to choose and work on up to 3 targets and should give priority to target areas where they are not already achieving.

Practices are required to commit to the Antibiotic target and their other targets by 31st August 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 Linda Smith- Crooked Bridge Road, Stafford

Targets

Group 1 – Antibiotic Prescribing				
	Target	Notes	%age of scheme	Target Selected <input type="checkbox"/>
1	The volume/rate of antibiotic prescribing should be no greater than National average (Dec 08 = 0.311 items/STAR PU), or a 5% reduction measured against baseline. (as measured Oct-Dec 09)	Inappropriate antibiotic prescribing contributes to the increase in C-Diff and MRSA infections. GP prescribing of antibiotics in SStaffs is the highest in the WM, and overall 9% above the national average. Target to be measured using the Health Care Commission measures in the PPD toolkit	20%	<input type="checkbox"/>
Group 2 – Value for money Indicators				
	Target	Notes	%age of scheme	Target Selected <input type="checkbox"/>
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.	10%	<input type="checkbox"/>
2	The proportion of ACE inhibitors to be no less than 75% of all ACE + AIIRA (sartan) prescribing. (or a 3%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	10%	<input type="checkbox"/>

3	Generic to branded modified release prescribing. PBC will be provided with a list of potential savings against three alternatives, Generic Iso mono 60mg vs Monomil, Fentanyl vs Matrifen and Mesalazine vs Mesren. Practices are required to achieve 50% of target savings.	In some cases alternative brands, which have been demonstrated to be bioequivalent to the brand leader are available at a significantly lower cost. TEVA has undertaken to guarantee to be the lowest cost brand. Practices should therefore consider changing patients to Monomil tablets, Mesren 400mg, MR Matrifen patches. These changes are also likely to be acceptable to patients as they will get consistency of product, which currently may not be the case. Practices will be notified of a potential savings figures	10%	
4	For the expenditure on blood glucose test strips not to exceed £73 per cost based endocrine STAR-PU (Measured Jan – Mar 2010 inc) or a 5% reduction from baseline.		10%	
5	For 92% 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	10%	
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)		10%	
7	The proportion of bisphosphonates prescribed as generic Alendronate to be no less than 80% (Measured Mar 10)		10%	

Group 3 – Quality Improvement

	Target	Notes	%age of scheme	Target Selected <input type="checkbox"/>
1	Audit prescribing transdermal analgesic patches	Transdermal analgesia costs are growing exponentially; there is significant variation	10%	

	used for chronic pain management (Submit Mar 10)	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.		
2	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	10%	
3	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	10%	
4	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)	Audit work conducted in other areas of the PCT Few patients have predicted FEV1 recorded (not able to assess compliance with NICE guidance) Registers show patients as Asthma rather than COPD.	10%	
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.	10%	
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	10%	