CL CCG Prescribing Incentive Scheme (2016/17)

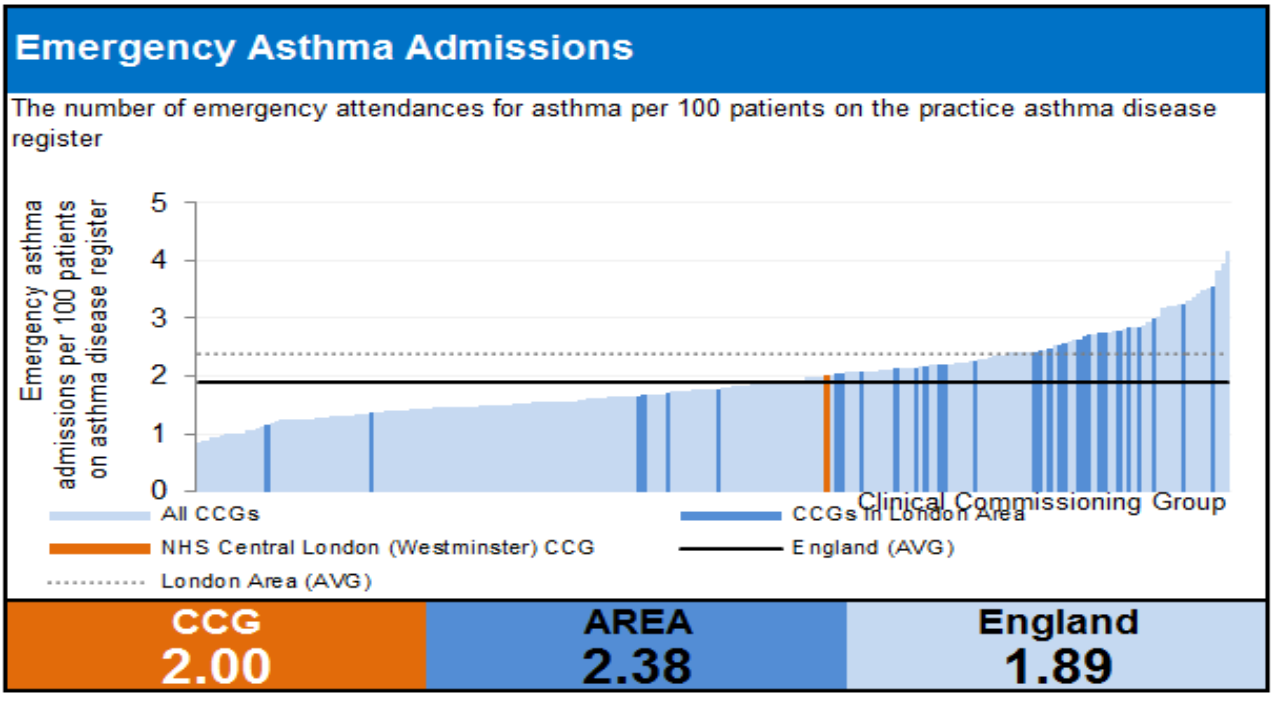
This year the structure of the Prescribing Incentive Scheme (PIS) includes the following:

Section no.	Component	Refer to page	Total available PIS payment
1	One main clinical indicator – Asthma	1	40%
2	A repeat prescribing audit cycle	6	30%
3	Two practice specific prescribing indicators - reflecting areas which require most improvement	15	10%
4	Meeting allocated prescribing budgets for both locality and practice	20	20%

Section 1 - Asthma

Central London CCG's spend on prescribed inhalers was £1.79 million between January 2015 and December 2015. This represents approximately 9% of the total primary care prescribing spend.

In CL CCG, during the period Jan 2014 – Dec 2014 there were 2 emergency asthma admissions per 100 patients on the asthma disease register. The graph below shows the CL CCG's emergency asthma admissions rate compared with other CCGs in London and England[1].



'Why Asthma Still Kills – National Review of Asthma Deaths' by the Royal College of Physicians[2] was published in May 2014. In response, the London Respiratory Network[3] identified seven key priorities which included:

Areas of concern for London identified from NRAD review	NRAD Recommendation	Action from London Respiratory Network & Children's Strategic Clinical Network Asthma Group
Inappropriate inhaler device or poor technique	Regular assessment of age appropriate inhaler technique to ensure effectiveness in all children and adults	Work to ensure that prescribed medications are taken in an appropriate way to maximise efficacy and reduce side effects. This requires training of practice, school and ED nurses
Inadequate use of personal action asthma plans (PAAPs)	Written PAAPs should be provided to all individuals with asthma and include information about management of acute symptoms and specific triggers	Work with named asthma leads and responsible respiratory prescribing (RRP) networks to understand current blocks to PAAP provision in London and identify and promote system enablers. Sign-post and promote PAAP tools for use in London (e.g. those from Asthma UK, Imperial College London). PAAPs should contain information about trigger factors for acute asthma attacks.

This element of the PIS is designed to encourage an improvement in patient asthma care, addressing the two priorities, outlined in the table above.

This section of the scheme is divided into two parts:

1. Attending a training event on inhaler technique organised by the CCG Medicines Management Team
2. Providing patients with a completed written Personal Asthma Action Plan (PAAP) and using inhaler device specific checklists as part of an asthma review

As good practice we would also recommend each practice to nominate one person as the lead for asthma care in line with current guidelines[2].

1.1 Attendance at inhaler technique training event

Criteria	Threshold (20% of total available PIS payment)
Number of clinical staff required to attend	Approximate target of $^{1}/_{3}$ of practice clinicians (with a compulsory attendance of at least 1 GP)*

**The exact number and type of clinicians required to attend from each Practice will be set individually for each practice, with the aims of making this both practical and meaningful for the practice.*

Patients diagnosed with asthma should have an annual review by a health professional that is competent to do so. However, evidence[4] suggests that the majority of healthcare professionals themselves do not have the necessary knowledge and skills to assess patients' inhaler technique or train them on the use of their inhalers.

The British Thoracic Society (BTS) guidance[5] suggests that an asthma review should include:

1) assessment of control
2) medication review and treatment adjustment if necessary
3) education, and issue, review or modification of a written asthma action plan
4) inhaler technique checking*
5) discussion around adherence and prescription filling and allergies (actions should be recorded)
6) an entry in the medical record that the patient has been given a PAAP

***The guidance reiterates:**

"Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique"

Most patients (up to 80%) cannot use their inhaler correctly[6]. This contributes to poor symptom control and exacerbations. To ensure effective inhaler use:

- **Choose** the most appropriate device for the patient before prescribing: consider medication, physical problems e.g. arthritis, patient skills, and cost; for inhaled corticosteroids (ICS) by pressurised metered dose inhaler, prescribe a spacer.
- **Check** inhaler technique at every opportunity. Ask the patient to show you how they use the inhaler. Check their technique against a device specific checklist.
- **Correct** using a physical demonstration, paying attention to incorrect steps. Check technique again, up to 2–3 times if necessary.
- **Confirm** that you have checklists for each of the inhalers you prescribe, and can demonstrate correct technique on them.[6]

1.2 Clinically review patient's inhaler technique and provide a written Personal Asthma Action Plan (PAAP)

Criteria	**Threshold (20% of total available PIS payment)**
Percentage of patients reviewed from a sample identified by your Practice Link Pharmacist	**30%** of patients (identified using a targeted SystmOne search) to be provided with written PAAP and have a completed inhaler technique checklist

A written Personal Asthma Action Plan (PAAP) should be provided for people with asthma, appropriate for their level of asthma control and health literacy, so they know how to recognise and respond to worsening asthma.[6]

The BTS guidance[5] presents substantial evidence that shared decision making, a structured review and education, as well as a PAAP reduces incidences of:

- Hospitalisation
- Emergency department attendance
- Unscheduled consultations

and also:

- Improves patient symptoms
- Reduces time off work
- Improves quality of life

The BTS provided evidence for the use of PAAPs in asthma is strong. This includes 22 systematic reviews of 261 randomised controlled trials which covers a wide range of demographic, clinical, and healthcare contexts (pre-school children, ethnic minorities, and in both primary care and secondary care).

The following are the components that are required for a 'good quality' PAAP: [6]

Component	Notes
Trigger for action is based on PEF measurement or symptoms (PEF based on percentage of patient's best peak flow)	Either peak flow or symptoms or both is fine
Standard written instructions	Beneficial in the evidence (although some management plans are now trying pictorial imagery rather than writing)
Traffic light configuration (red, amber, green)	No better than standard written instructions
Action plans usually include two to four parameters. Commonest: • increased use of short-acting beta agonist • initiation of oral corticosteroid • seeking medical advice if symptoms worsen	-

The PAAP used within the CWHHE* asthma template on SystmOne has been designed by Asthma UK[7], which includes all the above.

Documenting the review

Your Practice Link Pharmacist (PLP) will conduct a search, narrowing the pool of patients, in which we would like you to:

- provide a completed written PAAP to the patient (printed or electronic)
- demonstrate assessment of patient's inhaler technique using a device specific checklist (the checklists are embedded in the CWHHE asthma template)

* CWHHE Collaborative is the working partnership between Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups.

The SystmOne search identifies patients who potentially have poor asthma control, based on the National Review of Asthma Deaths, these include patients who are:

- READ coded as having poor inhaler technique
- READ coded as having an asthma exacerbation
- currently prescribed a high dose inhaled corticosteroid
- currently prescribed a LABA on its own in asthma
- prescribed more than 12 Salbutamol or Terbutaline inhalers in the last 12 months

A CWHHE asthma review SystmOne template has been created, which aims to support ease of use and consistency of information recorded.

On completion the following will be evaluated (End of Q4):

1. the READ code 'Patient has a written asthma personal action plan' is documented in each review post issuing a new, or updating a written PAAP
2. the following 2 criteria may also be subject to random check:
    a. the use of inhaler specific checklists are recorded as part of asthma review
    b. a completed written PAAP is present in patients' notes (electronic version or paper scanned)

References:

1. **Medicines Optimisation dashboard presented by NHS England (February 2016)**
https://www.england.nhs.uk/ourwork/pe/mo-dash/

2. **Why asthma still kills - The National Review of Asthma Deaths (NRAD)**
https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills

3. **London Respiratory Network report – summarises key recommendations from document above**
http://www.respiratoryfutures.org.uk/media/1684/london-respiratory-network-cyp-asthma-response-to-nrad.pdf

4. **Do healthcare professionals have sufficient knowledge of inhaler techniques in order to educate their patients effectively in their use?**
M Baverstock, N Woodhall, V Maarman, *Thorax* Dec 2010;**65**(Suppl.4):A117-A118

5. **British Guideline (BTS) on management of asthma**
http://www.sign.ac.uk/pdf/SIGN141.pdf

6. **Pocket guide for asthma Management and prevention; Global Initiative for Asthma 2016**
http://ginasthma.org/2016-pocket-guide-for-asthma-management-and-prevention/

7. **Asthma UK PAAP**
https://www.asthma.org.uk/advice/manage-your-asthma/action-plan/

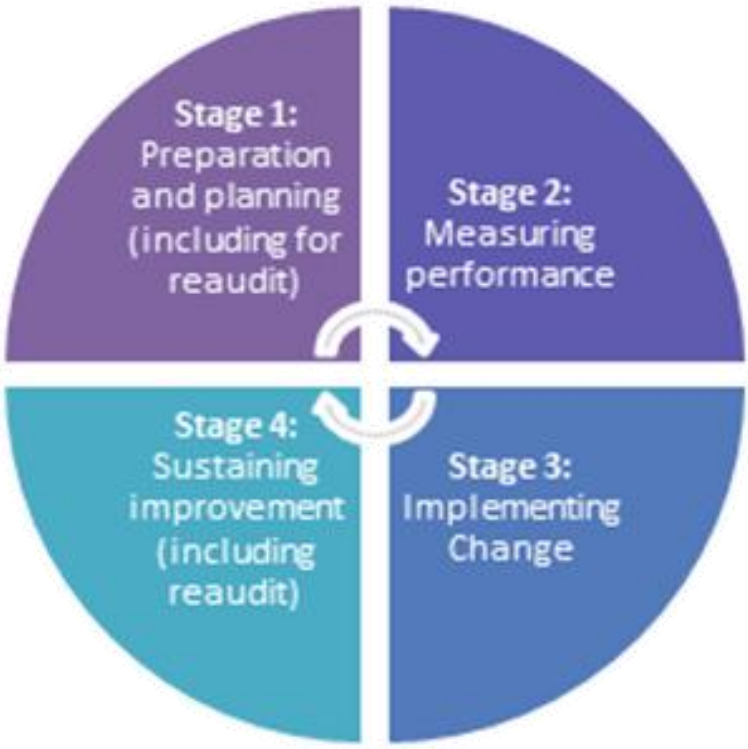
Section 2 - Repeat Prescribing Audit

Two thirds of prescriptions issued in primary care are repeat prescriptions[1]. These repeat prescriptions account for nearly 80 per cent of NHS medicine costs for primary care[1]. The management of these prescriptions and the time involved in processing them can be significant[1].

An effective repeat prescribing system can provide the following benefits[2]:

- Improved quality of prescribing and medicines use
- Improved patient safety
- Improved patient convenience and access to medicines needed
- Appropriate and efficient use of practice staff time and skills
- Managed workflow
- Waste reduction

This repeat prescribing audit will be a systematic review of current practice, process and performance to establish how well it meets predetermined criteria, by undertaking the stages demonstrated in the image below.



Stage 1. Preparation & Planning

Aim

To review and improve the repeat prescribing processes and policy currently in place.

Suggested standards

1. 60% of items should be issued using the electronic prescription service (EPS)
2. 90% of patients who have regular repeat prescriptions issued should have a medication review documented in the last 12 months[2]
3. Less than 20% of repeat items **DO NOT** have the quantities issued synchronised[†]
4. Less than 10% of prescription items **DO NOT** state appropriate directions on how medications should be taken[2]
5. Less than 10% of repeat items have been issued before the due date
6. Less than 10% of patients have a medication that has **NOT** been issued in the last 6 months[2]
7. 0% of prescription items **DO NOT** contain unintentional class of drug duplications[2]

Stage 2. Measuring Performance

Step 1 – Patient Identification
Identify a sample of 50 patients with a recent repeat prescription, chosen at random, over a flexible timeframe.

Step 2 - Data Collection
Complete the data collection proforma found in **Appendix 1a** (10 patients per proforma).

Step 3 – Analysis:
Conduct an analysis on the data collected by completing the final column named 'Total' on the proforma and **Appendix 1b.**

Step 4 – Action Plan
Arrange a meeting with your Practice Link Pharmacist (PLP) by the end of **Quarter 2** to discuss a Personalised Practice Action Plan and document on form found in **Appendix 2**.

A minimum number of areas for improvement and respective actions will be agreed with your PLP. The agreed action plan must include a timescale and delegated person(s) who will be accountable for managing the implementation of the respective action.

A date for re-audit should be agreed with your PLP and documented on the action plan.

Note: It is recommended that practices complete Steps 1- 4 by the end of Quarter 2 in order to ensure that a full audit cycle is completed by the end of financial year.

[†] Synchronising the prescribing interval allows better medicines management, since clinicians can more easily monitor repeat request intervals. It is also suggested that by enabling patients to collect all medicines at the same time (i.e. synchronising their ordering), compliance is likely to improve.

Stage 3. Implementing Change

Undertake the actions outlined in your completed Personalised Practice Action Plan.

Stage 4. Sustaining Improvement (Re-audit)

Step 1 – Patient Identification and Data Collection
Repeat Steps 1 to 3 as per Stage 2 (see above).

Step 2 – Summary
Complete the summary table provided in **Appendix 3**, which will summarise achievements post-implementation of action plan.

Step 3 – Submission
Submit the summary table (Appendix 3) completed in Step 2 to the Central London CCG Medicines Management Team.

Only the summary table in Appendix 3 should be submitted to:
medicinesmanagement@nw.london.nhs.uk

Please include the following subject title in your email: PIS Audit *(practice name)*

Deadline: 31st March 2017

Reviewing Repeat Prescribing Policy (Optional):
The Repeat Prescribing Checklist found in **Appendix 4** can be used to support practices when reviewing their repeat prescribing policy. For those practices that do not have a policy in place, this can be used to ensure essential information is covered. This does not need to be submitted as part of the PIS.

References:

1. **NHS England: Electronic Repeat Dispensing – Guidance**
https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf

2. **Clinical Effectiveness & Prescribing Programme (CEPP) National Audit: Repeat Prescribing**
http://www.awmsg.org/docs/awmsg/medman/CEPP%20National%20Audit%20-%20Repeat%20Prescribing.pdf

Appendix 1a. Repeat Prescribing Data Collection Proforma

Practice Name:

Date:

Criteria	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10	TOTAL
Percentage (%) of items issued using electronic prescription service (EPS) at the practice last month. This can be obtained using the following *http://systems.hscic.gov.uk/eps/stats/10novgpstats.xls*											**Latest estimated Percentage (%) of items issued using EPSr2 (figure from the hscic website):**
Has the patient had a medication review documented on SystmOne in the last 12 months?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	**Total number of patients that have had a medication review:**
Number of item(s) on repeat											**Total number of repeat items:**
Number of items on repeat that **NOT** synchronised e.g. 28 or 56 day supply * Please see below excluded items											**Total number of repeat items NOT synchronised:**
Number of items on repeat that **DO NOT** have appropriate directions? NB: PRN and MDU **alone** are not acceptable *For example: Tramadol 50mg capsules - Take as directed is not a legally valid prescription* ** Please see below excluded items											**Total number of repeat items that DO NOT have appropriate directions:**
Number of items on repeat where the last issue was made more than 1 week prior to the expected due ('End') date? *See screenshot. Issue history for each repeat item can be viewed using this icon:* 											**Total number of items issued before due date:**

This section should be completed by clinical staff

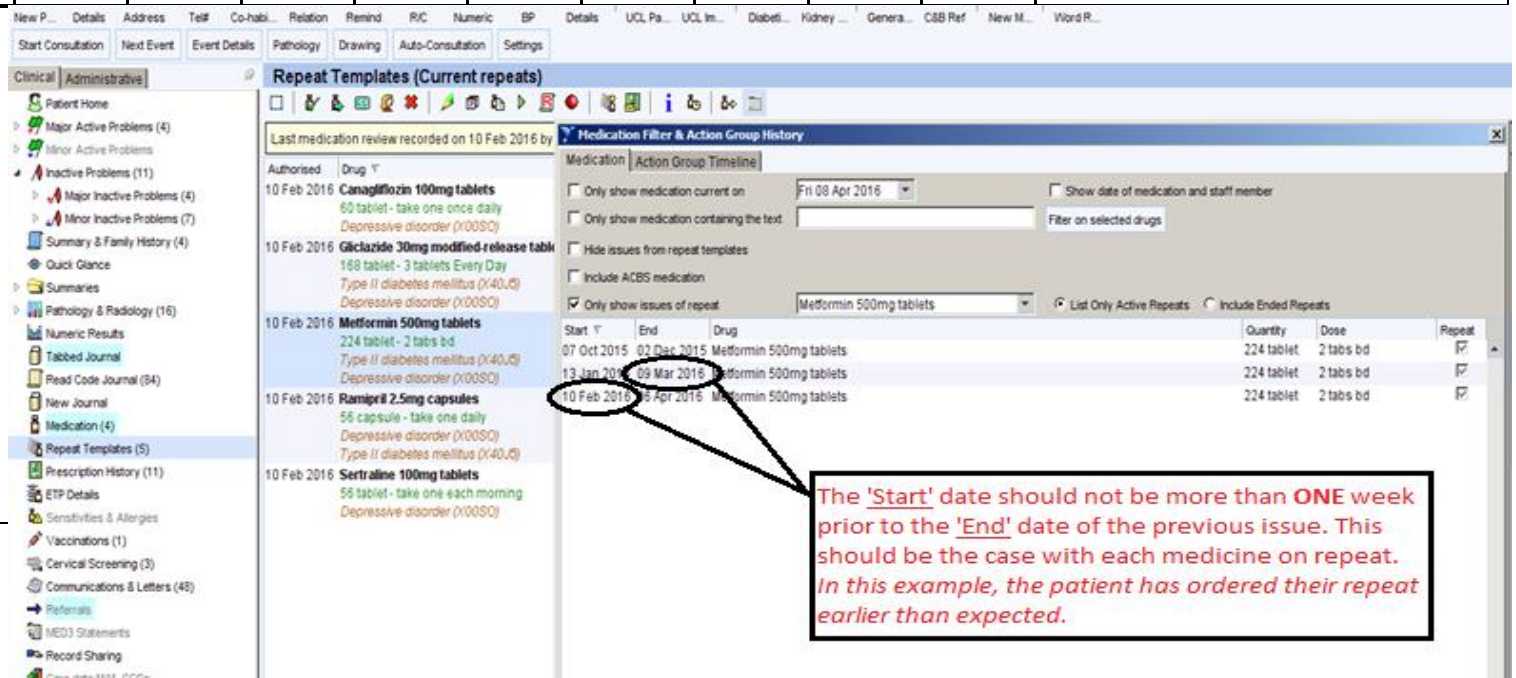
Criteria	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10	TOTAL
Number of items that have **NOT** been issued in the last 6 months *(excluding seasonal and PRN medications)*											**Total number of repeat items NOT issued in the last 6 months:**
Number of items that are unintended duplicate items from the same class of drugs *e.g. Beclometasone CFC-free inhaler AND Seretide Inhaler (this would be recorded as 2 items)*											**Total number of items with unintentional duplication:**
Comment											

*Excluding prescriptions for:

- Appliances e.g. stoma appliances, catheters
- Insulin
- Warfarin
- Rescue packs
- Emollients
- Controlled Drugs
- When required medications e.g. pain relief, laxatives

**Excluding prescriptions for:

- Insulin
- Warfarin
- Rescue packs
- Emollients
- Appliances e.g. stoma appliances, catheters



Appendix 1b. Repeat Prescribing Data Collection Proforma summary document

Criteria	Suggested standard	Total patients	Formulae	% Achieved
Percentage (%) of items issued using electronic prescription service (EPS) at the practice	60%			
Medication reviews documented on SystmOne in the last 12 months?	90%		(Total no. of patients who had a medication review ÷ 50 patients) x 100	
Criteria	**Benchmark**	**Total items**	**Formulae**	**% Achieved**
Total number of repeat item(s) across 50 patients				
Items on repeat that are **NOT** synchronised	Less than 20%		(Total no. of items **NOT** synchronised ÷ total number of repeat items reviewed) x 100	
Items on repeat that **DO NOT** have appropriate directions. NB: PRN and MDU **alone** are not acceptable	Less than 10%		(Total no. of items that **DO NOT** have appropriate directions ÷ total number of repeat items reviewed) x 100	
Items issued before due date	Less than 10%		(Total no. of repeat items issued more than 1 week prior to due date ÷ total number of repeat items reviewed) x 100	
Items that have **NOT** been issued in the last 6 months *(excluding seasonal and PRN medications)*	Less than 10%		(Total no. of repeat items **NOT** issued in last 6 months ÷ total number of repeat items reviewed) x 100	
items with unintentional duplication	0%		(Total number of repeats duplicated ÷ total number of repeat items reviewed) x 100	

Appendix 2. Personalised Practice Action Plan

Practice Name:

Date:

****REMINDER**** Arrange a meeting with your Practice Link Pharmacist to discuss your findings and formulate an action plan, ideally before 30th September 2016.

Area for Improvement	Target (%)	Action Plan	By Who	By When

Date of re-audit: _____

Appendix 3. Summary Table

Practice Name:

Date:

Summarise results of the audit and re-audit conducted, identifying whether targets set have been met after implementation of action plan.

Area for Improvement		Practice baseline (%) – prior to action plan	Target (%)	Re-audit (%) – achieved post action plan	Achieved
1.					YES / NO
2.					YES / NO
3.					YES / NO
4.					YES / NO

The summary table above (Appendix 3) is the **only** form which needs submission. Please submit to: medicinesmanagement@nw.london.nhs.uk

Please include the following subject title in your email: PIS Audit *(practice name)*

Deadline: 31st March 2017

Appendix 4. Repeat Prescribing checklist (Optional)[1]

Practice:

Date:

This checklist can be used as a tool to review the practice repeat prescribing policy.

Question	Yes/No/Comments
Does the practice have a written repeat prescribing policy?	Yes / No
Has the policy been reviewed in the last three years?	Yes / No
Is there an agreed time limit for processing repeat prescriptions?	Yes / No What is it?
Are additions/deletions to the repeat, including outpatient prescriptions and hospital discharges, **only** made by a GP, nurse or pharmacist?	Yes / No If No specify who else does this
Does the policy state the maximum number of repeat issues or the maximum length of time between reviews allowed?	Yes / No What is it?
Does the policy specify what to do if the patient requests a repeat which needs to be re-authorised?	Yes / No Please specify or reference in attached policy
Does the policy specify what to do if the patient requests an item which is not on repeat list?	Yes / No Please specify or reference in attached policy
Does the policy have specific details relating to repeat requests for high risk drugs, e.g. warfarin, lithium, DMARDs and controlled drugs?	Yes / No
Does the policy include details for flagging and recalling patients for medication review?	Yes / No
Are the notes/computer record clearly marked with date of present/future repeat medication review?	Yes / No
Does the policy state a system to review and archive repeats not requested for six months or more?	Yes / No Please specify
Does the policy include a process for adding prescriptions written during home visits to the repeat prescribing record?	Yes / No
Does the policy specify arrangements for communication between GP and community pharmacist or other healthcare professionals (e.g. designated GP and/or time to contact for prescription queries)?	Yes / No Please specify or reference in attached policy
All staff have signed to say they are aware of and understand the practice repeat prescribing policy?	Yes / No

Section 3 - Prescribing indicators

Each practice will have 2 prescribing indicators selected for them from the list below. Each indicator will be worth 5% of the total available PIS payment. The indicators selected will aim to address areas where the practice requires improvement.

1. Co-amoxiclav, cephalosporins & quinolone antibiotic items as % of all antibiotic items

	Threshold
Co-amoxiclav, cephalosporins and quinolone antibiotic items as % of all antibiotic items	**≤10.4%** *(NWL average Sept 15 – Feb 16 data)*

Evaluation will based on 6 months ePACT data (Q3 & Q4 2016/17).

2. Quantity of antibiotics prescribed per 1000 STAR PU

	Threshold
Quantity of antibiotics prescribed measured as antibacterial items per 1000 STAR PU	**≤449.82** *(NWL average Sept 15 – Feb 16 data)*

Evaluation will be based on 6 months ePACT data (Q3 & Q4 2016/17).

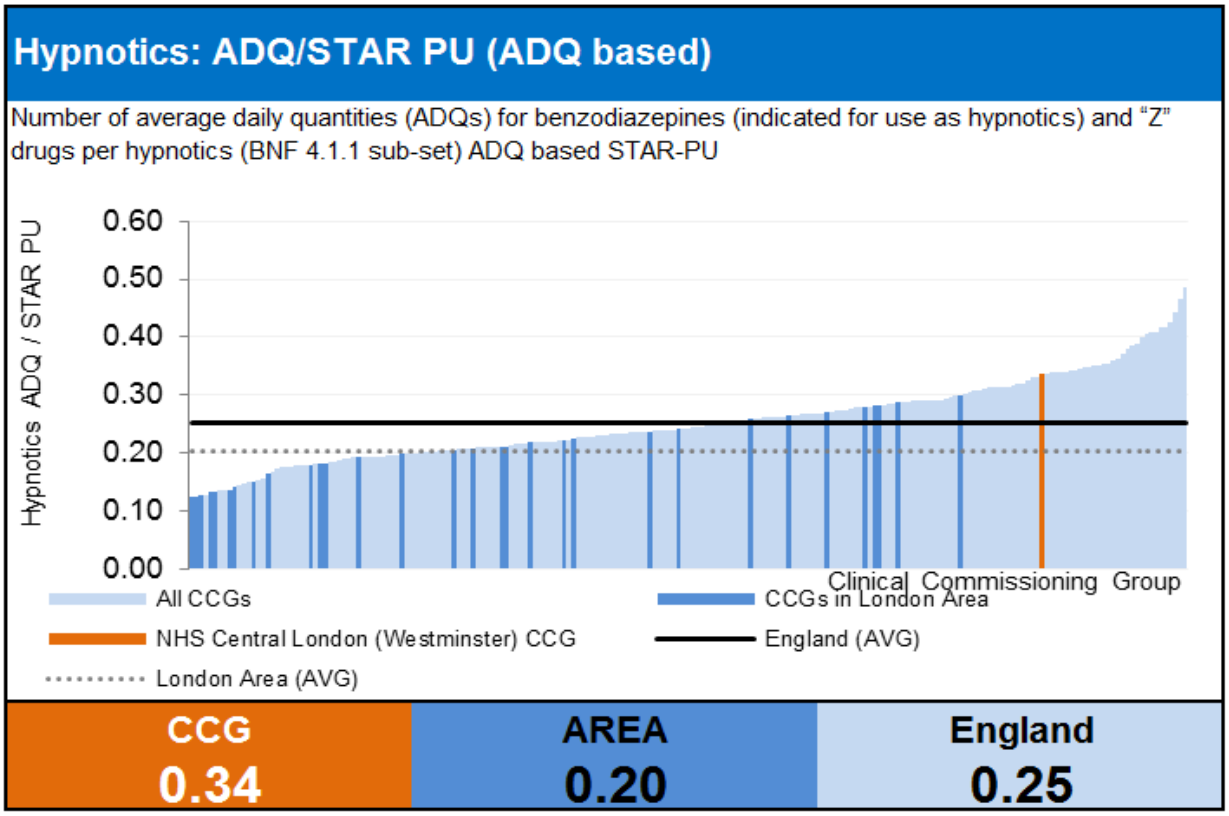
- Antibiotic resistance poses a significant threat to public health, especially because antibiotics underpin routine medical practice.
- Review and, if appropriate, revise current prescribing practice and use implementation techniques to ensure prescribing is in line with Public Health England (PHE) guidance on managing common infections and the Antimicrobial Stewardship in Primary Care collaboration TARGET antibiotics toolkit.
- Review the total volume of antibiotic prescribing against local and national data to help prevent the development of resistance.
- Review quinolone, cephalosporin, co-amoxiclav and other broad-spectrum antibiotic prescribing against local and national data. This is because they increase the risk of methicillin-resistant Staphylococcus aureus (MRSA), clostridium difficile and resistant urinary tract infections.[1]

3. Hypnotics Prescribing - benzodiazepines (indicated for use as hypnotics) and Z Drugs

	Threshold
Reduction in prescribing of hypnotics measured as ADQs per 1000 STAR PU	**5% reduction from practice baseline figure at Q4 2015/16**

Practices are asked to achieve a reduction in hypnotics prescribing (measured as ADQ per 1000 STAR PU) of at least 5% from their baseline figure from Q4 2015/16. This indicator will be evaluated using Q4 2016/17 data.

The graph below shows the CL CCG's total hypnotics prescriptions in July –Sep 2015 compared with other CCG in London and England.[2]



Although there has been a reduction in overall hypnotic prescribing locally, Central London CCG still has the highest total volume of hypnotics prescribing in London.

- The risks associated with hypnotics, such as falls, cognitive impairment, dependence and withdrawal symptoms, are well recognised.
- Hypnotics should be used only if insomnia is severe, using the lowest dose that controls symptoms for short periods of time.
- Review and, if appropriate, revise prescribing of hypnotics to ensure that it is in line with national guidance[1].

This indicator includes the following hypnotics (as per BNF 4.1.1):

- Flunitrazepam
- Flurazepam Hydrochloride
- Loprazolam Mesilate
- Lormetazepam
- Nitrazepam
- Temazepam
- Zolpidem Tartrate
- Zopiclone

4. Three-day courses of antibiotics for uncomplicated urinary tract infection

	Threshold
Number of average daily quantities (ADQs) per item for trimethoprim 200mg tablets, nitrofurantoin 50mg tablets and capsules, nitrofurantoin 100mg m/r capsules and pivmecillinam 200mg tablets.	**≤6.22** *(NWL average , Dec 15 – Feb 16 data)*

Evaluation will be based on 3 months ePACT data (Q4 2016/17).

- A 3-day course of antibiotics is sufficient for acute symptomatic uncomplicated urinary tract infection in most women who are not pregnant.
- Review and, if appropriate, revise current prescribing practice and use implementation techniques to ensure prescribing of 3-day courses of antibiotics is in line with Public Health England (PHE) guidance on managing common infections[1].

Uncomplicated UTI has been defined as infection in a woman with a normal urinary tract and normal renal function. The guidance advises that 7-day courses should be used for men with UTI. In addition, a back-up or delayed antibiotic strategy should be considered for women with mild UTI symptoms and supporting information about antibiotic strategies, infection severity and usual duration should be given.

Nitrofurantoin (100 mg modified-release twice daily) is recommended first-line for people with a glomerular filtration rate (GFR) of over 45 ml/min because general resistance and community multi-resistant Escherichia coli (E. coli) are increasing. If GFR is between 30 and 45 ml/min, nitrofurantoin should be used only if drug resistance is a problem and there is no alternative. Depending on local resistance patterns, or if GFR is less than 45 ml/min, trimethoprim (200 mg twice daily) or pivmecillinam (400 mg 3 times daily) are recommended as alternative first-line options. Note that, based on evidence that the higher dose is more effective, the dose of pivmecillinam recommended by PHE differs from the licensed dose of 400 mg immediately followed by 200 mg 3 times daily.

A Cochrane review (CD004682) supports the use of 3-day courses of antibiotic therapy for uncomplicated UTI. Symptomatic failure rate was assessed and, at both short- and long-term follow-up, no significant difference was found in the number of people who still had symptoms after 3-day, or 5- to 10-day, courses of antibiotic treatment. However, shorter courses of antibiotic treatment were associated with a 17% reduction in side effects. The review concluded that **3 days of antibiotic therapy is similar in effectiveness to 5 to 10 days** for achieving symptomatic cure in women aged 18–65 years who are not pregnant. Longer courses of treatment were more effective than 3 days of treatment in achieving bacteriological cure. Therefore, longer courses may be considered in complicated UTI (for example, pyelonephritis, pregnancy and recurrent UTI) if eradication of bacteriuria is important.

Numerator: Total average daily quantity (ADQ) usage for trimethoprim 200mg tablets, nitrofurantoin 50mg tablets and capsules, nitrofurantoin 100mg m/r capsules and pivmecillinam 200mg tablets.

Denominator: Total number of prescription items for trimethoprim 200mg tablets, nitrofurantoin 50mg tablets and capsules, nitrofurantoin 100mg m/r capsules and pivmecillinam 200mg tablets

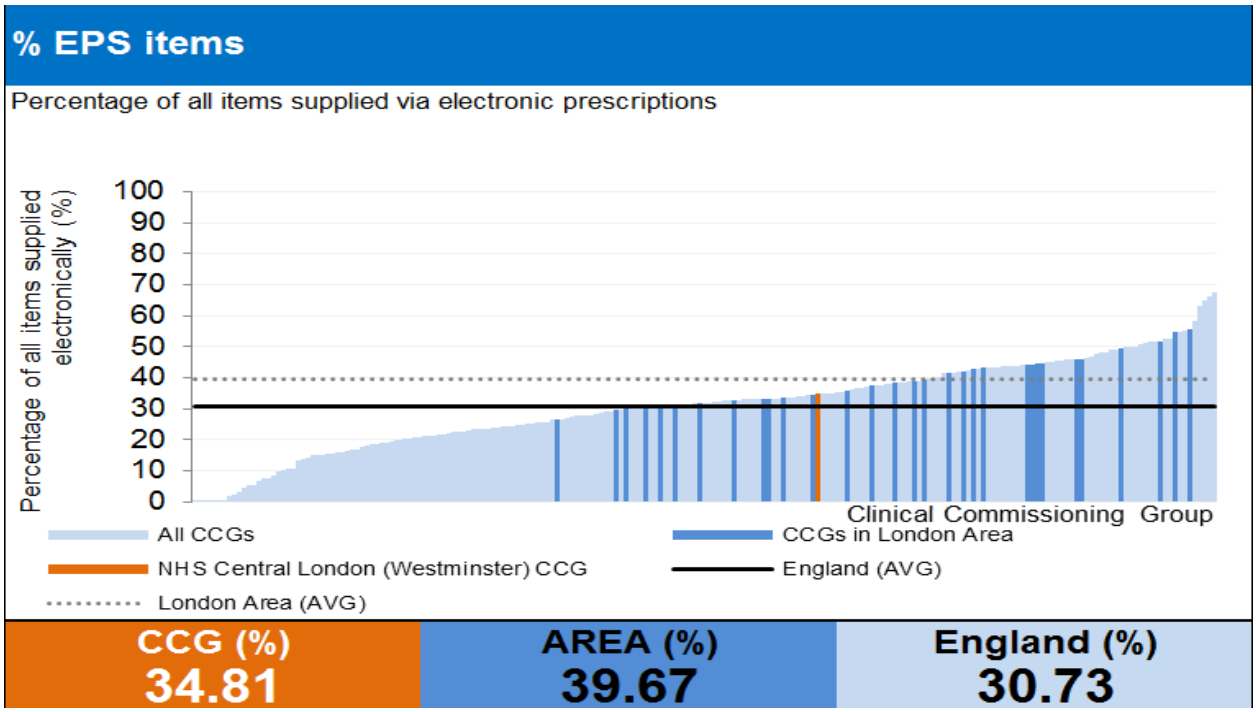
An ADQ value of 3 equates to 3 day courses of the above presentations and therefore the comparator value is a proxy for the proportion of 3 day courses prescribed.
The aim of the comparator is to support local discussion. In accordance with guidance, prescribing for urinary tract infections may need to be for longer than 3 days e.g. elderly, males, complicated UTI. Therefore a comparator value of, or near to, 3.0 would not be appropriate.

5. Total Electronic Prescription items (via EPS) as % of all prescriptions

	Threshold
Prescription items dispensed using EPS as a % of all prescription items	**50% and over**

Evaluation will based on 3 months ePACT data (Q4 2016/17).

The graph below shows percentage of all items supplied via electronic prescriptions for CL CCG between July and September 2015[2].



The following are the main benefits of EPS for both GP practice staff and patients[3]*:*

GP Practice staff	Patients and carers
Less time signing prescriptions	There is no need for patients to pick up paper

	prescriptions from the GP practice
Prescriptions can be cancelled at any time until they have been dispensed, replacements can be sent electronically	No paper prescriptions being used thus avoiding possible loss
Less time dealing with prescription queries: • Standardised prescription information will reduce queries from dispensers. • Improved prescription accuracy leads to a reduction in the likelihood of patients receiving the wrong medication. • Electronic prescriptions cannot be lost, reducing the risk of duplicate prescriptions being generated.	Saves patient time, as prescriptions are electronically sent to pharmacies selected by the patient
Process repeat prescriptions more efficiently: • Reduces workload associated with printing, sorting and re-authorising repeat prescriptions • No need to post prescriptions	Patients are offered more choice about where to get their medicines from
Electronic prescriptions are sent straight to the dispenser of the patient's choice. This will result in a reduction in footfall in reception as patients won't be visiting to collect prescriptions.	If the prescription needs to be cancelled the GP can electronically cancel and issue a new prescription without the patient having to return to the practice
No need to fax urgent or replacement prescriptions. These can be sent electronically by the prescriber	Pharmacies can have patients' repeat prescriptions ready before they arrive, thus reducing waiting times
Less time preparing for prescription collection services	

References:

1. **NICE Key Therapeutic Topics**
   https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-advice/Key-therapeutic-topics/medicines-optimisation-ktt-feb-16.pdf
2. **NHS England Medicines Optimisation Dashboard**
   https://www.england.nhs.uk/ourwork/pe/mo-dash/
3. **Health and Social Care Information Centre**
   http://systems.hscic.gov.uk/eps/gppractice/getstarted/index_html

Section 4 - Expenditure indicator

There are 2 elements to the Expenditure Indicator:

Part 1 - Each practice's adjusted spend does not exceed its allocated 2016/17 practice prescribing budget by more than 2.5%

Part 2- Each Locality's adjusted spend does not exceed its allocated 2016/17 Locality prescribing budget

Each element above is worth 10% of the total available PIS payment. **Note: to qualify for Part 2, practice must achieve Part 1.**

PIS payments

The total CCG budget for the Prescribing Incentive Scheme 2016/17 is £200,374.
The maximum payment that can be achieved by a Practice is calculated as follows:

£200,374 x (Practice ASTRO PU ÷ Total CCG ASTRO PU)

	Outline	% of total available PIS payment
Section 1 – Asthma care (Total 40% of PIS payment)	**Part 1** Attendance at inhaler technique training event. Threshold Agreed no. and type of clinical staff (approx. 1/3 of clinical staff) to attend sessions **Part 2 & 3** Review patient's inhaler technique. Provide a Personal Asthma Action Plan & document the review. Threshold 30% of patients identified through the targeted SystmOne search to be reviewed and session documented.	20% 20%
Section 2 – Repeat prescribing audit (Total 30% of PIS payment)	**Part 1** Conducting initial data collection + analysis (i.e. up to Stage 2, Step 3) **Part 2** Action plan implementation and re-audit (i.e. full audit cycle up to completion of Stage 4)	10% 20%
Section 3 – Prescribing indicators (Total 10% of PIS payment)	Practices will be invited to work on 2 prescribing indicators. This will reflect a clinical area which requires improvement in the practice.	5% for indicator 1 5% for indicator 2
Section 4 – Expenditure (Total 20% of PIS payment)	**Part 1** Practice's adjusted spend does not exceed the allocated practice prescribing budget by more than 2.5%. **Part 2** Locality adjusted spend is less than the allocated Locality prescribing budget	10% *plus* 10% (only obtained if part 1 is achieved)

Prescribing Incentive Scheme agreement form

Practice Name:
Date
Practice Link Pharmacist Name:

Section Number 1 - Asthma		
Section Lead: ……	**Signature:** ……	**Date:** ……
Agreed minimum number of clinical staff to attend asthma training event: ……		

Section Number 2- Repeat prescribing audit cycle		
Section Lead: ……	**Signature:** ……	**Date:** ……

Section Number 3- Prescribing indicators (Select TWO only)		**Tick if selected**
Co-amoxiclav, cephalosporins & quinolone antibiotic items as % of all antibiotic items		
Quantity of antibiotics prescribed per 1000 STAR PU		
Hypnotics Prescribing - benzodiazepines (indicated for use as hypnotics) and Z Drugs		
Three-day courses of antibiotics for uncomplicated urinary tract infection		
Total Electronic Prescription items (via EPS) as % of all prescriptions		
Section Lead: ……	**Signature:** ……	**Date:** ……

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) 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 1997 and have been further adjusted in 2009, and in 2013. The new weights are known as ASTRO (13) PUs.

The weightings are shown below. Temporary resident data is now not collected as practices are reimbursed by a different method and so there is no weighting for temporary residents. The name has not been changed to ASO PUs as people are familiar with the term ASTRO PU. ASTRO PUs were devised from the total of all drug costs it is therefore not correct to use ASTRO PUs for making comparisons within therapeutic groups. There are differences in the age and sex of patients for whom drugs in specific therapeutic groups are usually prescribed.

Age (years)	Cost-based ASTRO (2013) PUs	
	Male	**Female**
0-4	1.0	0.9
5-14	0.9	0.7
15-24	1.2	1.4
25-34	1.3	1.8
35-44	1.8	2.6
45-54	3.1	3.7
55-64	5.3	5.4
65-74	8.7	7.6
>75	11.3	9.9

(b) STAR-PUs - Specific Therapeutic group Age-sex Related Prescribing Units

STAR PUs have been developed based on costs within therapeutic groups. STAR PUs have been developed for the eight leading therapeutic groups, i.e. gastrointestinal, cardiovascular, respiratory,

central nervous system, infection, endocrine, musculoskeletal and skin, which together account for 85% of prescribing in England. STAR-PU weightings were also updated in 2013.

(c) ADQs - Average Daily Quantities

The ADQ is based on the prescribing behaviour within England. It represents the assumed average maintenance dose per day for a drug used for its main indication in adults. The ADQ is an analytical unit, which can be used to compare treatment activity and not a recommended dose.

ADQs are a more accurate measure of prescribing activity compared to the number of items. The indicator measures the total volume prescribed for each drug strength, for a given time period and calculates the total quantity of daily doses e.g. 1 ADQ for ibuprofen is 1.2g.

For further information see the Health and Social Care Information Centre website