WEST NORFOLK PRESCRIBING INCENTIVE SCHEME 2013/14

Approved by WN Executive Team subject to sign off by WN Governing Body

1.	**INTRODUCTION**		
1.1	• West CCG budget for 13-14 is being set at outturn. • Practice budgets will be allocated using AstroPUs weighted for prevalence and deprivation, as agreed by the West Norfolk CCG as in 12-13 • Continuity with 2012/13 and building on existing good work		
1.2	Practices can obtain a maximum of 80p per patient on their list at 1st January 2014 if they come within their allocated prescribing budget for 2013-14 and achieve the following. NB: overspending on your 2013/14 prescribing budget will exclude you from qualifying for the scheme.		
1.3	If practices achieve and maintain the savings identified in paragraph 2.4 below (i.e. their agreed three QIPP projects) by the end of Q1 13-14 (i.e. July 2013 PACT data), then, as a reward, the practice will receive an additional incentive payment; equal to the savings made in the three QIPP project areas during July 2013, compared to Jan to March 2013 baseline.		
1.4	Any windfall savings will be discounted when calculating savings made for paragraph 2.3 see Appendix 1 for definition of windfall.		
1.5	Practices will be required to submit a plan of how the money is to be spent including, how patients will benefit, in order to receive their Incentive Scheme payment. The Practice Patient Participation Group should be involved in developing this plan.		
2	**PROPOSED SCHEME**		
	All measurements will be on the average Q4 data for 2013/14		
	Value	**Required activity**	
2.1	10p	• Participate in Prescribing Advisor Annual Visit (between April and June 13) and at least one follow-up meeting at six months • Practice Champion to attend quarterly meetings as arranged by West Norfolk CCG • Practice Champion to facilitate a regular (possibly monthly - min 6) prescribing slot in a practice meeting. At each meeting one Prescribing QIPP project to be discussed in detail using the monitoring data reports and the Key Message documents. • Participate in the West Norfolk CCG Diabetes QIPP project. Attend training and set up joint clinics in practice. Complete audits and submit outcomes sheet to Prescribing Team.	
2.2	10p	Agree a quality area for improvement, which has been identified as a priority for your practice, at the Prescribing Advisor Visit and undertake agreed action including an audit and re audit if appropriate. For suggested areas see Table 1	
2.3	40p = 80%, 30p = 70%, 20p = 60%, 10p = 50%	Achieve a proportion of your individual practice WN Medicines Optimisation QIPP 13-14 savings target (calculated using Jan-Mar 2013 pact data - to be forwarded when available). For details please see Table 2 Savings can be made in a different way to the West Norfolk CCG agreed NHSN&W projects but need to be in the same area and full details and evidence will need to be provided.	
2.4	10p - 20p (dependant on achievement / work carried out)	Achieve Key Performance Indicators for your top prescribing medicines optimisation QIPP project and two others from the top 5 as identified and agreed by the prescribing team. See 1.3 above	
	Total = 80p		

Table 1

Medicines Optimisation of : -	Recommended Change	Rationale for change
Antidepressants	Use of low cost SSPIs as first choice.	NICE.
Antibiotics	Reduce volume of prescribing.	Not necessary for many infections.
Antibiotics	Reduce cefs, quins & co-amox as per formulary.	Need to limit resistance and reduce the risk of C Diff.
NSAID	Prescribe ibuprofen / naproxen first choice.	Prescribe lowest risk oral NSAIDs.
NSAID	Risk Benefit discussed and documented in patients notes.	Accountability for prescribers.
NSAID	Dual prescribing with gastroprotection in high risk groups including joint prescribing of SSRIs or long-term steroids	To reduce GI risk.
NSAID	Ensure appropriate monitoring; U and Es, FBC - baseline, 3 months then every 6 months	To monitor side-effects.
NSAID	Review NSAID patient with reducing renal function	To avoid adverse drugs reaction.
PPIs	Review all PPI patients to stop/ step down.	National guidelines. Potential s/e.
High Risk Drugs e.g. warfarin, methotrexate, steroids	Ensure all patients are issued the appropriate hand held record and that there are systems in place to complete them.	National recommendations.
High Risk Drugs e.g. amiodarone, methotrexate	Ensure robust systems are in place for monitoring of these drugs.	Monitor as per Summary Product Characteristics and national / local guidance.

Table 2

Medicines Optimisation of : -	Recommended Change	Rationale for change	Target	Details	Potential Annual Savings based on Nov/Dec 12 Jan 13 data
Pain - Neuropathic pain management - 1	Prescribe gabapentin before pregabalin as per neuropathic pain pathway / local guidelines.	Gabapentin more cost effective	86%	% amitriptyline & gabapentin of neuropathic p'way drugs	£291,294
Pain - Neuropathic pain management - 2	Ensure highest strength pregabalin is prescribed BD.	All pregabalin strengths are flat priced and licensed BD as well as TDS			
Pain - Neuropathic pain management - 3	Review pregabalin and gabapentin and consider either stop or switch from pregabalin to gabapentin.				
Respiratory	Ensure step down of ICS in asthma.	National Guidelines	74%	% LD ICS items of all ICS	£271,753
Respiratory	Ensure appropriate inhaler technique.	National Guidelines			
Respiratory Cost Effective Device	Seretide 250 Evo to 500 Accuhaler (COPD)	More cost effective			
Respiratory Cost Effective Device	Low dose combination to Fostair	More cost effective			
Respiratory Cost Effective Device	Seretide 125 Evo to Flutiform 125 MDI	More cost effective			
Respiratory Cost Effective Device	Seretide 250 Evo to Flutiform 250 MDI (Asthma)	More cost effective			
Angiotensin receptor antagonists	using category M first-line	More cost effective	98%	% cat M ARAs of all ARAs (12-13 target = 90%)	£165,849
Housekeeping Drugs	various	More cost effective		50% of suggested switches	£139,125
Statins and Ezetimibe	Prescribe simvastatin / pravastatin / atorvastatin first-choice.	More cost effective	97%	% sim, prav, ator of all statins & ezetimibe	£149,159
Bladder stability drugs	Please prescribe generic plain oxybutynin then tolterodine first line	More cost effective	50%	% plain oxybutynin / tolterodine of all BS drugs	£132,744
Calcium Channel Blockers	Prescribe amlodipine or lercanidipine first line	most cost effective option, use lercanidipine second line	70%	% amlod / lercan of all CCBs	£98,981
Diabetes BGTS	prescribe BGTS with a cost per 50 strips for £10 or less first-line	More cost effective	60%	% cost effective BGTS	£86,743
Diabetes BGTS	Review patients in line with local guidance.	Only use if appropriate			
Diabetes - Cost effective Insulins	Start new patient on most cost effective product in class. Use NPH first line in patients with Type 2 diabetes being started on	As per NICE guidance.	40%	% cost effective Int/LA insulin	£73,343

	insulin				
DROP list - Drugs of Low Priority	Reduce prescribing of DROP List drugs.	Drugs of Low priority - not first-choice / no or limited evidence		Reduce cost of these drugs by 10%	£61,809
Diabetes Needles and lancets	Ensure the most cost effective and appropriate size needles and lancets are prescribed.		60%	% cost effective needles	£59,339
Triptans	Prescribe cost-effective triptans		90%	% cost effective triptans of all oral triptans	£59,119
Stoma Products and Appliances	Reduction in prescribing of accessories and following recommendations.	Not all routinely necessary and can be bought		Reduce costs by 5%	£54,836
Stoma Products and Appliances	Appropriate quantities of appliances to be prescribed on repeat.				
Stoma Products and Appliances	Appropriate prescribing to Stoma patients.				
Dipyridamole	Switch dipyridamole (MR and liquids) to clopidogrel for secondary prophylaxis of ischaemic strokes & TIA. NB stop aspirin unless individual's clinical condition suggests both aspirin and clopidogrel are indicated.		95%	% clopidogrel of clopidogrel and MR dipyridamole	£41,839
Venlafaxine	Prescribe, plain generic, XL tabs or cost effective branded capsules		95%	% cost effective tabs, XL tabs / caps of all XL	£37,314
Prednisolone EC	Prescribe plain oral prednisolone first-line		98%	% plain prednisolone of all oral prednisolone	£17,812
Long Acting Muscarinic Antagonists	Review need and appropriate preparation.				£100,000
Total					**£1,549,765**

Appendix 1 – Additional Information

Windfall Saving – a savings made purely as a result of a change in the Drug Tariff reimbursement without any change in prescribing behaviour by the practice or if prescribing of certain drugs move out of primary care such as shared care drugs moving to specialist commissioning.

Payment – will be made once March 2014 epact data is available.

Appendix 2

PRIMARY CARE TRUSTS INCENTIVE SCHEME PAYMENTS

Approved Uses

1. The purchase of material or equipment which is to be used for the treatment of patients or members of the practice, including diagnostic equipment, ECG machines, blood testing equipment, sterilisers, nebulisers, foetal heart detectors, cryothermic probes, defibrillators and related consumables. (Where practice staff have made significant savings in the cost of dressings and wound management, we would encourage the purchase of items for use by nursing staff, e.g. vascular Doppler equipment).

2. Payments to dieticians or counsellors providing advice on diet, lifestyle, alcohol consumption or smoking.

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

4. The purchase of computers including hardware and software.

5. Non-recurring staff costs.

6. Initiatives to improve prescribing.

7. The purchase of material or equipment relating to health education including television, videos, leaflets and posters and payment for advice on how best to disseminate health education advice to patients.

8. Investment in existing practice premises where the improvement or development proposals are consistent with the Primary Care Investment Plan.

Purposes for which Practice Incentive Surplus Payments may *not* be spent

1. The purchase of services or equipment which are unconnected with healthcare.

2. To reduce a practice's contribution to the employment costs of existing practice staff.

3. The purchase of land or premises.

4. To pay off existing loans or mortgages taken out by the members of the practice or third-party landlords.

5. The purchase of drugs, medicines or appliances.

6. The purchase of hospital services.

7. Practice premises investment where the development proposals are not consistent with the Primary Care Investment Plan.