Prescribing Incentive Scheme (PIS) 2013/14

Brighton and Hove Clinical Commissioning Group

Background

The purpose of the scheme is to encourage high quality cost-effective prescribing

Principles

- Incentives should reward improvement in patient care and health outcome. It is therefore important that the prescribing incentive scheme does not simply reward low cost prescribing, but should include criteria relating to the quality of prescribing.
- To ensure financial stability within the CCG, it is vital that the CCG and its constituent practices maintain control of prescribing costs. However a reduction of costs at the expense of patient health or healthcare is not acceptable.
- The incentive scheme should encourage practices to consider both cost and quality, and hence cost-effectiveness of their prescribing, and reward practices appropriately.
- The CCG recognises that where practices are already achieving the targets specified in the scheme they should be rewarded in the same way as those practices meeting the targets for the first time.

Performance against budget

Practices will not be assessed for performance against their prescribing budget, which is an indicative amount. They will however be expected to continue to be vigilant about prescribing costs and take steps to ensure that any unnecessary waste is eliminated.

Scheme details

The scheme will consist of the following targets.

	Target Areas	Weighting for points	Assessment
1	Annual visit and action plan	2	Joint submission of completed work
2	Incontinence drugs	1	Review
3	Long acting muscarinic antagonist (LAMA) inhalers	1	Review
4	Erectile dysfunction drugs	1	Review
5	Benzodiazepines	2	ePACT / Toolkit data for Jan-March 2014
6	Pregabalin	1	Review
7	Bisphosphonates	1	Review
8	Formulary adherence	1	Eclipse software
9	Lansoprazole step down	1	Review

Where practices do not have any prescribing of these preparations (for said condition), they can contact their Pharmaceutical Advisor for a suitable alternative area for review
Submission of review by 15th March 2014, using the forms provide, as this enables data to be collated, and recurring issues to be identified.
Submissions not in the required format will be rejected.

There will be £175,000 available to practices to incentivise the achievement of these targets.
Payments for satisfactory achievement of the targets will depend on:

- Practice list size (measured in ASTRO-PUs)
- The number of targets achieved by the practice.

See appendix for further information on potential payments.
In the event of any over-commitment all payments will be scaled down pro rata to a total of £175,000.

Finances

- Any payment made to a practice under the prescribing incentive scheme will be held by the CCG. National guidelines govern the types of expenditure that are permitted using these payments. Payments should be used for the benefit of the patients of the practice, having regard to the need to ensure value for money

- It should be noted that these payments cannot be used for the purchase of health care (hospital or community services), or for drugs.

- In the event of a dispute over a practice's entitlement, it will first be discussed between the practice and the head of Prescribing. If no decision can be reached it will be discussed at the CCG's Medicines Management Committee for a decision. This will include sharing all relevant data with the Medicines Management Committee as required for them to be able to make an informed decision.

- To ensure financial stability of the CCG, there will be a maximum total payment under the prescribing incentive scheme of £175,000 with scaling down of the payments for the targets if payments would otherwise exceed this amount.

AUTHORISED PURPOSES OF PRESCRIBING INCENTIVE PAYMENTS

1. The purchase of material or equipment which is to be used for the treatment of patients of the members of the practice including diagnostic equipment, ECG machines, blood testing equipment, sterilisers, nebulisers, fetal heart detectors, cryothermic probes and defibrillators.
2. Payments to dieticians or counsellors providing advice on diet, life-style, alcohol consumption or smoking.
3. The purchase of material or equipment which will enhance 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.
4. The purchase of computers including hardware and software relating to improving patient care.
5. Non-recurring staff costs.
6. Initiatives to improve prescribing i.e. prescribing advice and support
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.

PURPOSES ON WHICH PRESCRIBING INCENTIVE PAYMENTS MAY NOT BE SPENT

1. The purchase of services or equipment which are unconnected with health care.
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 pre-existing loans taken out by the members of the practice.
5. The purchase of drugs.
6. The purchase of hospital services.

Katy Jackson, Head of Prescribing and Medicines Commissioning, April 2013

1. Annual Prescribing Visit

Practice meets with CCG Pharmaceutical Adviser at least annually, agree and facilitate the implementation of a practice specific prescribing work plan.

This prescribing work plan will be implemented with the aid of the Medicines Management Team, via:

- Identification of appropriate switches and reviews
- Liaison with the respective prescribers in facilitating the implementation of these switches and reviews
- Working with the Practice Prescribing Lead to produce a summary of the actions / outcomes that result from the implementation of the work plan.

Criteria of achievement

Submission of a year-end final report on outcomes of implementation of Prescribing work plan by 15th March 2014

2. Incontinence drugs

Proposal

Immediate release (IR) tolterodine to be 1st choice for new patients with overactive bladder (OAB) and mixed urinary incontinence (UI) who have not responded to bladder training. This agent has been chosen in preference to oxybutynin as it is generally better tolerated.

- Identify patients with repeat prescriptions for solifenacin.
- Where patients have been prescribed it for more than 6 weeks, review with the patient (**face to face or telephone**) for efficacy and tolerability.
- Stop if it is not being taken / not working / not tolerated, in such patients, a switch to tolterodine IR can be considered in cases where the patient has not tried it, but ensure a review of efficacy and tolerability is carried out after 4-6 weeks.
- Where patients are recommended solifenacin by secondary care it would be reasonable to start tolterodine IR if they have not tried it before.

Complete and submit required data collection and summary sheet by 15/03/2014

Rationale

Antimuscarinic drugs are recommended for the treatment of overactive bladder (OAB) and mixed urinary incontinence (UI), if 6 weeks of bladder training has been ineffective. Differential diagnosis of UI based on bladder diaries, along with bladder training and supervised pelvic floor exercise is available from the Community Bladder & Bowel Service.
http://www.sussexcommunity.nhs.uk/services/servicedetails.htm?directoryID=16279

The draft NICE consultation (due for publication in July 2013) has identified:

- oxybutinin immediate release (IR), tolterodine IR and propiverine IR as the most effective antimuscarinics, and these should be prescribed 1st line.
- 2nd line choices are: either an alternative 1st line drug, or trospium (IR) or oxybutynin (MR)
- **The prescribing of solifenacin, tolterodine MR, propiverine MR, trospium MR and fesoterodine is NOT recommended, as they are the least effective options.**

If this advice remains in the final NICE guidelines, these preparations will be removed from the Joint Formulary.
NICE acknowledge the high rates of discontinuation with all antimuscarinic drugs due to adverse effects and lack of data on long-term efficacy.

It may take 4 weeks for the full benefits of treatment to become apparent, and a treatment review should be offered 4-6 weeks after starting a new antimuscarinic treatment.
If there is little or no improvement, or intolerable adverse effects, change the dose or try an alternative recommended antimuscarinic, and review again.

Locally, solifenacin accounts for 40% of antimuscarinic prescribing items, and 60% of the cost, and there is evidence to suggest that it is often the first choice. There is also evidence that many women do not receive reviews to ensure treatment continues to be effective and tolerated.
Please note that mirabegron is not currently included in the Joint Formulary, and is therefore not available as an option

References

NICE CG40 The Management of Urinary Incontinence in Women (update due July 13)
Urinary incontinence in women: full guideline DRAFT (Corrected 1 March 2013) p10 and p 125
http://www.nice.org.uk/nicemedia/live/13019/62658/62658.pdf

Incontinence review

Practice:_____ Practice Lead: _____ Date: _____

Search on: solifenacin

Pt ID	Duration of solifenacin treatment (if less than 4 weeks, do not proceed)	From review (either face to face or telephone) please indicate with Y / N if:			Action taken
		Is it still being taken?	Is incontinence reduced?	Are side effects tolerable?	

Incontinence review

Practice	
Practice Lead	
Date	

Please give details of any learning points or actions taken by the practice as a result of this review:

Submit to Medicines Management Team by 15th March 2014

3. Long acting muscarinic antagonist inhalers: Aclidinium▼

Proposal

- COPD patients newly requiring LAMA to be offered aclidinium.
- At annual COPD reviews, offer patients the option to change from tiotropium to aclidinium. *(To aid this, placebo inhalers can be obtained from by emailing: info.uk@almirall.com)*

NB the manufacturers of aclidinium advise that it should be used with caution if recent MI, unstable angina, newly diagnosed arrhythmias, or hospitalisation for heart failure in the past year.
Since aclidinium is a new drug, please report any adverse effects through the yellow card scheme.
Complete and submit required summary sheet by 15th March 2014

Rationale

NICE COPD guidelines recommend:
In people with stable COPD who remain breathless or have exacerbations despite use of short-acting bronchodilators as required, offer the following as maintenance therapy:

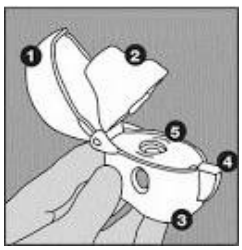
- if FEV1 ≥ 50% predicted: either long-acting beta2 agonist (LABA) or long-acting muscarinic antagonist (LAMA)
- if FEV1 < 50% predicted: either LABA with an inhaled corticosteroid (ICS) in a combination inhaler, or LAMA.
- Offer LAMA in addition to LABA+ICS to people with COPD who remain breathless or have exacerbations, irrespective of their FEV1.

The guidelines stress the importance of choice of device, stating:
"If the patient is unable to use a particular device satisfactorily, it is not suitable for him or her, and an alternative should be found."

Until recently, there has been one LAMA available in 2 different devices: tiotropium in a Handihaler® or Respimat®.
The Respimat® has been associated with a small increase in risk of mortality, and since it has no added benefit, its routine use is not recommended.

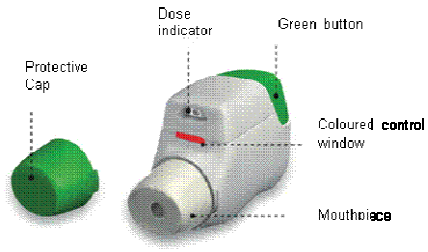
A further choice of device is provided by aclidinium (Eklira Genuair®), a relatively new LAMA; there is no evidence of any difference in efficacy, the device is cheaper and easier to use. The dose of 1 puff twice daily is delivered by pressing a button once to release a dose before inhaling, a window which changes colour as the dose is loaded, a click sound after inhaling successfully and a dose indicator. These features should enhance correct inhaler use and prevent accidental overdose

Handihaler®



1 Dust cap
2 Mouthpiece
3 Base
4 Piercing button
5 Centre chamber

Genuair®



References

NICE CG 101 June 2010: Management of chronic obstructive pulmonary disease in adults in primary and secondary care
http://www.nice.org.uk/nicemedia/live/13029/49397/49397.pdf
Beasley R et al Call for worldwide withdrawal of tiotropium Respimat mist inhaler BMJ 2012;345:e7390
http://www.bmj.com/content/345/bmj.e7390

Review of LAMA prescribing

Practice	
Practice Lead	
Date	

No. of patients on COPD register	
No. with recorded inhaler technique check	
No. switched to aclidinium	
No. of new inititations	

Please give details of any learning points or actions taken by the practice:

Submit to Medicines Management Team by 15th March 2014

4. Erectile dysfunction

Proposal

New patients qualifying for NHS prescription for phosphodiesterase type-5 inhibitors (PDE5 inhibitor) should be prescribed sildenafil, and exposed to a minimum of 4 (preferably 8) doses up to the highest tolerated dose before switching to an alternative PDE5 inhibitor.

- All patients on NHS prescriptions for PDE5 inhibitors should be reviewed to clarify eligibility.
- Patients prescribed sildenafil by brand to be switched to generic.
- Patients taking tadalafil or vardenafil should be switched to sildenafil if appropriate

Complete and submit required data collection and summary sheet by 15/03/2014

Rationale

Three selective PDE5 inhibitors are licensed for the treatment of erectile dysfunction – sildenafil, tadalafil and vardenafil. They are all included in the joint formulary. These medications have proven efficacy and safety; the major difference between them is that sildenafil and vardenafil are relatively short-acting drugs, with a half-life of approximately 4 hours, whereas tadalafil has a longer half-life of 17.5 hours.
In addition, sildenafil absorption may be delayed when taken with food while tadalafil is unaffected, so patients should be advised accordingly

Over half of all NHS prescriptions issued for PDE5 inhibitors in Brighton & Hove are for sildenafil.

The Viagra® patent is due to expire June 2013 and the generic price is expected to drop significantly and quickly.
Cialis® remains in patent until the end of 2017, and Levitra® until the end of 2018.

Prescribing on the NHS:

Drug treatments for erectile dysfunction may only be prescribed on the NHS under certain circumstances. PDE5 inhibitors should not be prescribed on the NHS except to treat erectile dysfunction in men who:

i. Have diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida or spinal cord injury.
ii. Are receiving dialysis for renal failure.
iii. Have had radical pelvis surgery, prostatectomy (including transurethral resection of the prostate), or kidney transplant.
iv. Were receiving Caverject, Erecnos, MUSE, Viagra or Viridal for erectile dysfunction at NHS expense on 14 September 1998.
v. Are suffering severe distress as a result of impotence. In this case, the patient must be assessed by a specialist; in Brighton & Hove, this is provided by the ED clinic based at the Hove Polyclinic.

Health Service Circular recommends one treatment per week at NHS expense, based on research evidence in the 40-60 age group. Prescribers can use their clinical judgement to prescribe more, but should bear in mind that these medications have a street value.

References

Lilly, UKSPC for Cialis (2006)
Bayer, UKSPC for Levitra (2006)
Pfizer, UKSPC for Viagra (2006)
British Society for Sexual Medicine Guidelines on the Management of Erectile Dysfunction
http://www.bssm.org.uk/downloads/BSSM_ED_Management_Guidelines_2007.pdf
HCS 1999/148 : Treatment for impotence. NHS Executive
http://webarchive.nationalarchives.gov.uk/20120503190154/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012086.pdf

PDE5 Inhibitor review; search on sildenafil, tadalafil, vardenafil, including brand names

Practice:
Date:

Pt ID	Drug & strength & no. of treatments per script	Reason for NHS prescribing	No. of treatments issued in last 6 months	If patient is receiving more than 1 treatment per week, is the reason recorded?	If not currently on sildenafil:	
					Record of having tried sildenafil previously?	Is the patient suitable for switching to generic sildenafil?

Review of drugs for erectile dysfunction

Practice	
Practice Lead	
Date	

Number of patients receiving NHS prescribed PDE5 inhibitors	
Number ordering more than 1 treatment per week	
Number ordering more than 1 treatment per week with recorded reasons	
Number of patients on tadalafil or vardenafil	
Number switched to sildenafil	

Please give details of any learning points or actions taken by the practice as a result of this review:

Submit to Medicines Management Team by 15th March 2014

5. Benzodiazepines and Z-drugs

The term "benzodiazepine" used in the following text includes Z-drugs.

Proposal:

- To build on the successes of the last two years schemes, which have resulted in an 11% year on year drop in benzodiazepine and Z drug prescribing across Brighton & Hove.

- Based on October-December 2011 and 2012 national data shows Brighton and Hove has:
  - the 4th highest drop in prescribing in terms of ADQ per STAR PU (0.355) and
  - 21st highest percentage reduction in England

- Individualised Practice Benzodiazepine Prescribing Target will be based on a move towards a 30% reduction in ADQ/STAR PU [from October – December 2012 level] or the national average for October – December 2012 (1.55), whichever is higher.

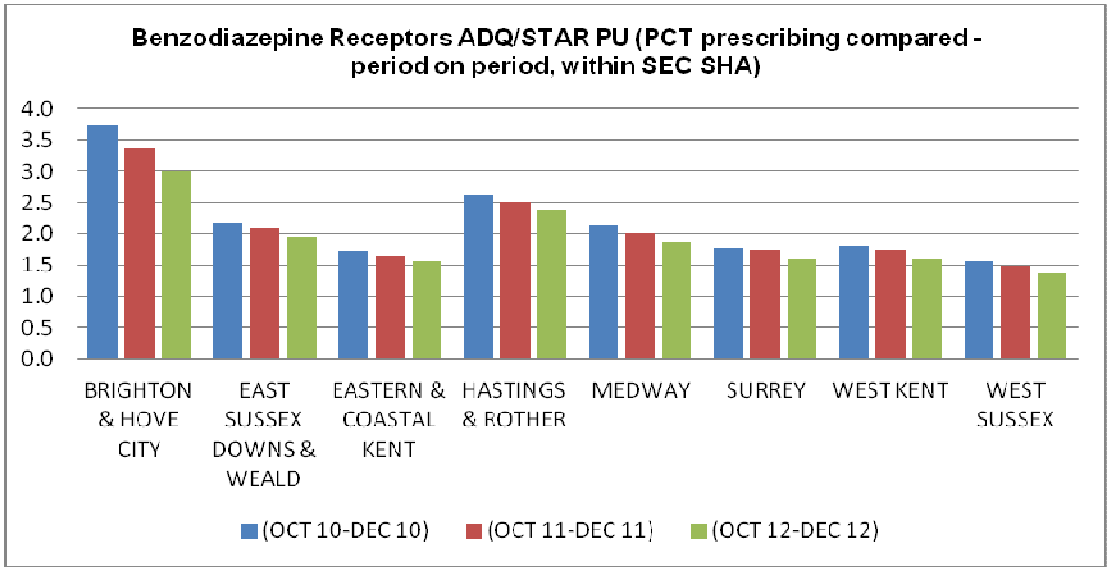
The achievement of this target will be measured by ePACT for January – March 2014. A maximum of 2 points will be awarded using a sliding scale from October – December 2012 baseline to the individualised practice target

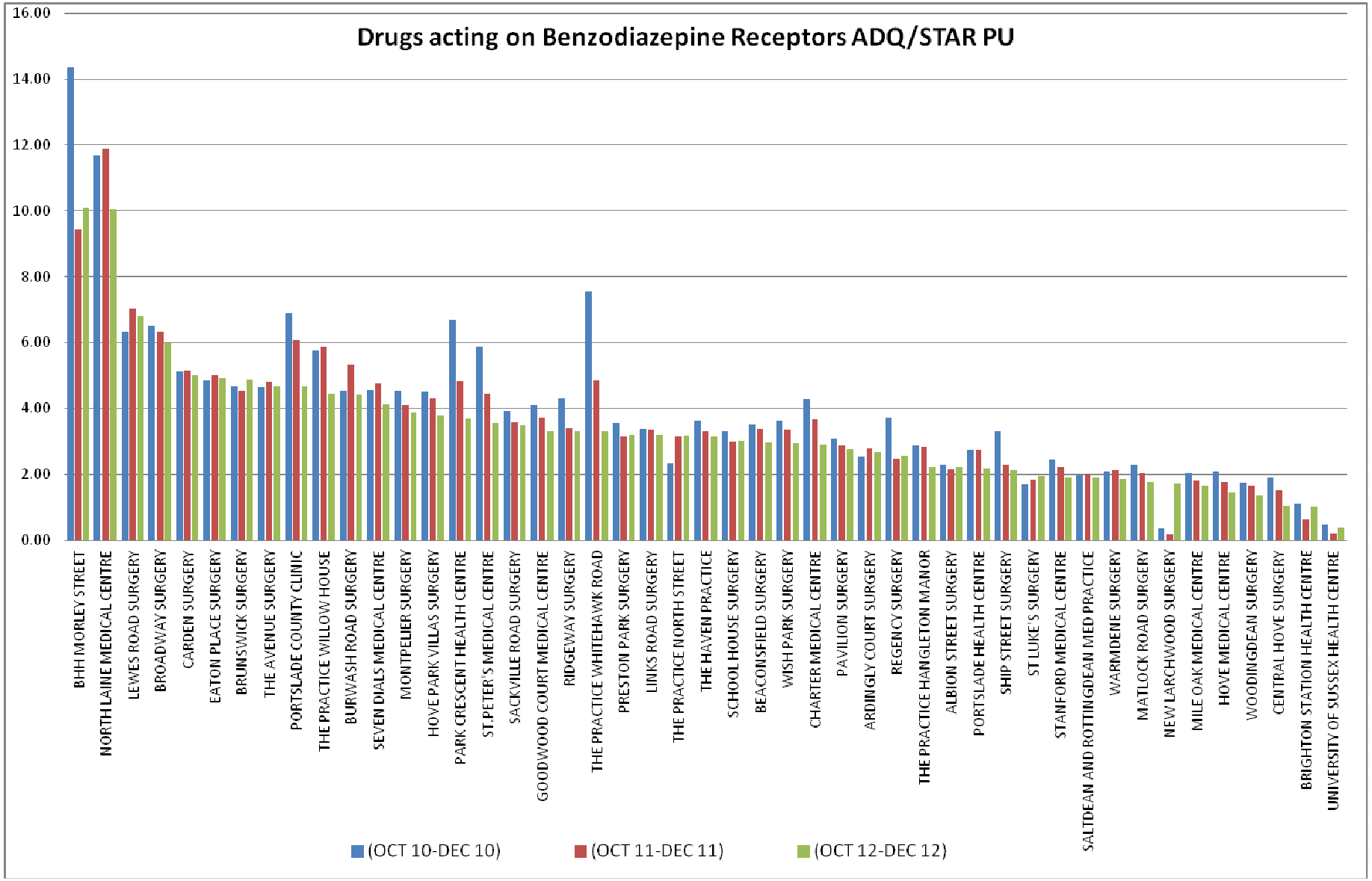
Please note that patients who are reducing Subutex/ methadone should not attempt benzodiazepine reduction at the same time

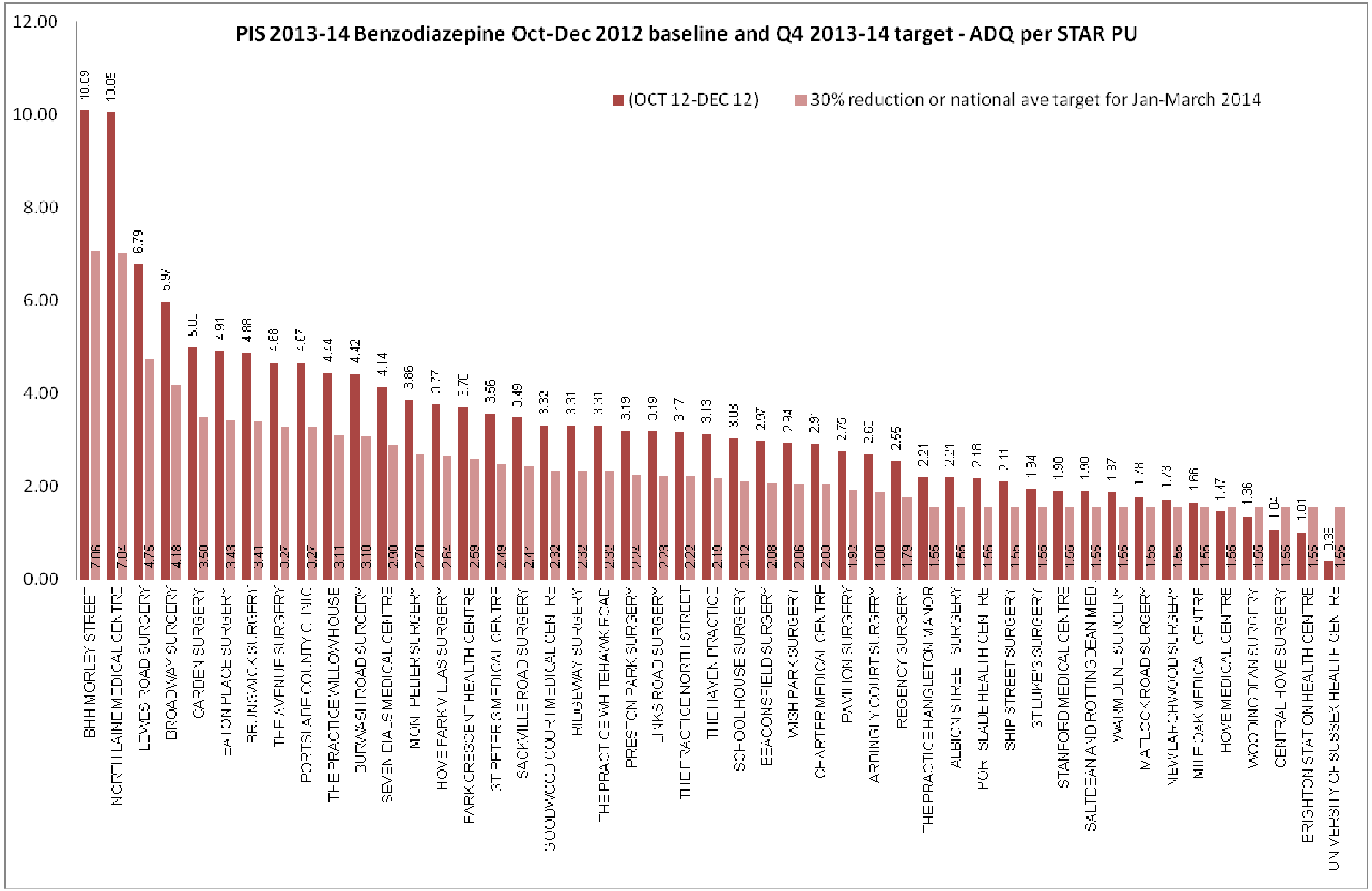
For support and information see website
http://www.staff.brightonandhoveccg.nhs.uk/resources/central-nervous-system

Rationale

- Brighton & Hove has highest level of benzodiazepine prescribing in England (excluding the Isle of Man).
- Over 50% of the drug related deaths in Brighton & Hove identified the presence of benzodiazepines in toxicology reports.
- Long term use of benzodiazepines is not licensed – the maximum recommended treatment is 2-4 weeks. Dependence and tolerance can develop within days.
- Long term benzodiazepine use is associated with an increased risk of falls and fractures, road traffic accidents, memory loss, confusion, ataxia, low mood and insomnia.
- Withdrawal syndrome can develop any time up to 3 weeks after stopping treatment and can result in anxiety symptoms, distorted perceptions, and rarely, seizures, and hallucinations. Dose reduction and withdrawal should therefore be done gradually.




Drugs acting on Benzodiazepine Receptors ADQ/STAR PU
16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
BHH MORLEY STREET
NORTH LAINE MEDICAL CENTRE
LEWES ROAD SURGERY
BROADWAY SURGERY
CARDEN SURGERY
EATON PLACE SURGERY
BRUNSWICK SURGERY
THE AVENUE SURGERY
PORTSLADE COUNTY CLINIC
THE PRACTICE WILLOW HOUSE
BURWASH ROAD SURGERY
SEVEN DIALS MEDICAL CENTRE
MONTPELIER SURGERY
HOVE PARK VILLAS SURGERY
PARK CRESCENT HEALTH CENTRE
ST PETER'S MEDICAL CENTRE
SACKVILLE ROAD SURGERY
GOODWOOD COURT MEDICAL CENTRE
RIDGEWAY SURGERY
THE PRACTICE WHITEHAWK ROAD
PRESTON PARK SURGERY
LINKS ROAD SURGERY
THE PRACTICE NORTH STREET
THE HAVEN PRACTICE
SCHOOL HOUSE SURGERY
BEACONSFIELD SURGERY
WISH PARK SURGERY
CHARTER MEDICAL CENTRE
PAVILION SURGERY
ARDINGLY COURT SURGERY
REGENCY SURGERY
THE PRACTICE HANGLETON MANOR
ALBION STREET SURGERY
PORTSLADE HEALTH CENTRE
SHIP STREET SURGERY
ST LUKE'S SURGERY
STANFORD MEDICAL CENTRE
SALTDEAN AND ROTTINGDEAN MED PRACTICE
WARMDENE SURGERY
MATLOCK ROAD SURGERY
NEW LARCHWOOD SURGERY
MILE OAK MEDICAL CENTRE
HOVE MEDICAL CENTRE
WOODINGDEAN SURGERY
CENTRAL HOVE SURGERY
BRIGHTON STATION HEALTH CENTRE
UNIVERSITY OF SUSSEX HEALTH CENTRE
(OCT 10-DEC 10)
(OCT 11-DEC 11)
(OCT 12-DEC 12)


PIS 2013-14 Benzodiazepine Oct-Dec 2012 baseline and Q4 2013-14 target - ADQ per STAR PU
(OCT 12-DEC 12)
30% reduction or national ave target for Jan-March 2014
12.00
10.00
8.00
6.00
4.00
2.00
0.00
BHH MORLEY STREET 10.09 7.06
NORTH LAINE MEDICAL CENTRE 10.05 7.04
LEWES ROAD SURGERY 6.79 4.75
BROADWAY SURGERY 5.97 4.18
CARDEN SURGERY 5.00 3.50
EATON PLACE SURGERY 4.91 3.43
BRUNSWICK SURGERY 4.88 3.41
THE AVENUE SURGERY 4.68 3.27
PORTSLADE COUNTY CLINIC 4.67 3.27
THE PRACTICE WILLOWHOUSE 4.44 3.11
BURWASH ROAD SURGERY 4.42 3.10
SEVEN DIALS MEDICAL CENTRE 4.14 2.90
MONTPELIER SURGERY 3.86 2.70
HOVE PARK VILLAS SURGERY 3.77 2.64
PARK CRESCENT HEALTH CENTRE 3.70 2.59
ST PETER'S MEDICAL CENTRE 3.56 2.49
SACKVILLE ROAD SURGERY 3.49 2.44
GOODWOOD COURT MEDICAL CENTRE 3.32 2.32
RIDGEWAY SURGERY 3.31 2.32
THE PRACTICE WHITEHAWK ROAD 3.31 2.32
PRESTON PARK SURGERY 3.19 2.24
LINKS ROAD SURGERY 3.19 2.23
THE PRACTICE NORTH STREET 3.17 2.22
THE HAVEN PRACTICE 3.13 2.19
SCHOOL HOUSE SURGERY 3.08 2.12
BEACONSFIELD SURGERY 2.97 2.08
WISH PARK SURGERY 2.94 2.06
CHARTER MEDICAL CENTRE 2.91 2.03
PAVILION SURGERY 2.75 1.92
ARDINGLY COURT SURGERY 2.68 1.88
REGENCY SURGERY 2.55 1.79
THE PRACTICE HANGLETON MANOR 2.21 1.55
ALBION STREET SURGERY 2.21 1.55
PORTSLADE HEALTH CENTRE 2.18 1.55
SHIP STREET SURGERY 2.11 1.55
ST LUKE'S SURGERY 1.94 1.55
STANFORD MEDICAL CENTRE 1.90 1.55
SALTDEAN AND ROTTINGDEAN MED. 1.90 1.55
WARMDENE SURGERY 1.87 1.55
MATLOCK ROAD SURGERY 1.78 1.55
NEWLARCHWOOD SURGERY 1.73 1.55
MILE OAK MEDICAL CENTRE 1.66 1.55
HOVE MEDICAL CENTRE 1.47 1.55
WOODINGDEAN SURGERY 1.36 1.55
CENTRAL HOVE SURGERY 1.04 1.55
BRIGHTON STATION HEALTH CENTRE 1.01 1.55
UNIVERSITY OF SUSSEX HEALTH CENTRE 0.38 1.55

6. Pregabalin

Proposal

To reduce prescribing of pregabalin through ensuring the local Pregabalin Prescribing Policy – December 2012 is followed for:

- All new patients being treated for neuropathic pain or generalized anxiety disorder.
- Reviewing established patients with repeat prescriptions for pregabalin who have current or historic substance misuse, and stopping prescribing as per policy.

Complete and submit required data collection and summary sheet by 15/03/2014

Rationale

There is increasing evidence that pregabalin is abused and traded illicitly. There is difficulty in managing this as the drug has a number of legitimate licensed indications.

To move towards a more managed situation, a local policy (Pregabalin Prescribing Policy – December 2012) has been developed, with greater limitations on primary care prescribing, and work continues with providers to manage prescribing in secondary care.

Prescribing pregabalin to patients with a history of substance misuse has been included in the "Drugs not for routine prescribing in Primary Care Policy April 2013 "

Where pregabalin has been successful in controlling pain, gabapentin will also be effective. Local experience suggests that titrating gabapentin dose up to 1200mg tds is frequently effective. The BSUH pain service is aware of the issues, and is prepared to advise; contact the Pain Service at Hove Polyclinic.

Where a patient is also accessing substance misuse service (SMS), their care co-ordinator will incorporate pregabalin changes into the care plan, please ensure care co-ordinators are kept informed

Where a patient is using or suspected of using other recreational drugs, SMS open access may be appropriate to support pregabalin withdrawal.

For patients experiencing anxiety, consider referring to the Wellbeing service, either to see one of the primary mental health practitioners and/ or access CBT or workshops.

Review of pregabalin prescribing

Practice	
Practice Lead	
Date	

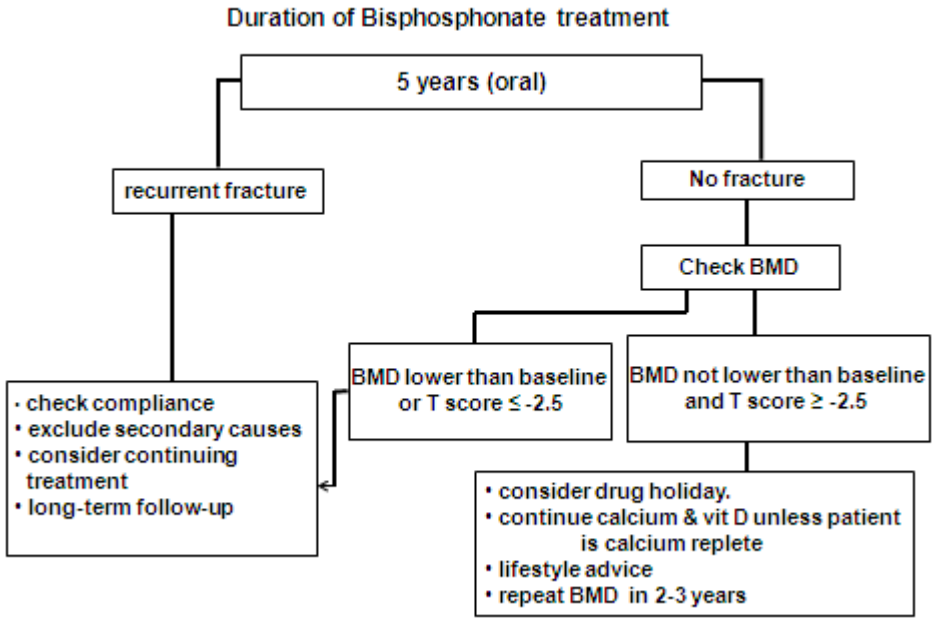
No. of patients with prescriptions for pregabalin	
No. of these with a record of substance misuse (SM)	
No. of SM patients stopped / undergoing pregabalin withdrawal / switched to an alternative	

Please give details of any learning points or actions taken by the practice

Submit to Medicines Management Team by 15th March 2014

7. Bisphosphonate withdrawal

Proposal: To review patients who have been on bisphosphonate treatment for osteoporosis for 5 years or more and instigating a drug holiday where appropriate, as per the flow chart below



Complete and submit required summary sheet by 15/03/2014

Rationale

Bisphosphonates have a well-established place in the treatment of osteoporosis.
They bind strongly to bone mineral and inhibit bone turnover, and this effect lasts for many months after treatment has stopped. This has led to the concern that long term treatment may increase bone fragility by suppressing normal bone remodelling, essential for repair of skeletal micro-damage.

There is some controversy over the ideal duration of therapy, particularly with the emergence of links with the rare but serious complications of osteonecrosis of the jaw and atypical subtrochanteric fracture.

The majority of studies of bisphosphonates lasted less than 5 years; however, the results of a few study extensions suggest that patients with bone mineral density (BMD) measured as femoral neck T score greater than -2.5 after 3-5 years of treatment and who did not suffer further fragility fractures, are unlikely to benefit from continued treatment.

In patients receiving oral bisphosphonates (alendronate, ibandronate, risedronate and etidronate), treatment is usually given for five years in the first instance. If bone mineral density (BMD) remains the same or has improved from baseline, the post-treatment femoral neck T-score is greater than –2.5 and no fractures have occurred during treatment, it is advisable to discuss a bisphosphonate treatment holiday for two to three years, with reassessment of fracture risk at the end of that time and re-continuation of treatment if indicated.

Patients on a treatment holiday can be legitimately excluded from the osteoporosis QoF targets

Patients who had a previous fragility fracture who should continue treatment if T score is below –2.5

NOTE: this does not apply to patients who continue to take oral steroids, since they continue to have an increased fracture risk. Such patients should be excluded from this review.

References

- Black DM et al. Continuing Bisphosphonate Treatment for Osteoporosis — For Whom and for How Long? NEJM 366: 22; 2051-2053 http://www.osteoporosis-resources.org.uk/implementation/22-duration-of-treatment
- NHS Lothian Referrral Guidelines

Review of bisphosphonate prescribing

Practice	
Practice Lead	
Date	

No. of patients with repeat prescriptions for alendronate, risedronate, ibandronate, etidronate	
No. reviewed	
No. started on drug holiday	

Please give details of any learning points or actions taken by the practice

Submit to Medicines Management Team by 15th March 2014

8. Formulary Adherence Indicator

Proposal

- Formulary adherence as measured in quarter 4 of 2013-14 (January to March 2014) to be 90% or more across all therapeutic areas.

  Where this target is not achieved, practices are invited to submit a management plan detailing areas for improvement the practice will be taking in order to achieve this target.

- All Practices are advised to have processes in place to review current prescribing practice in order to ensure continuance of formulary compliance.

- Practices will be supplied with a list of non formulary drugs prescribed

Rationale

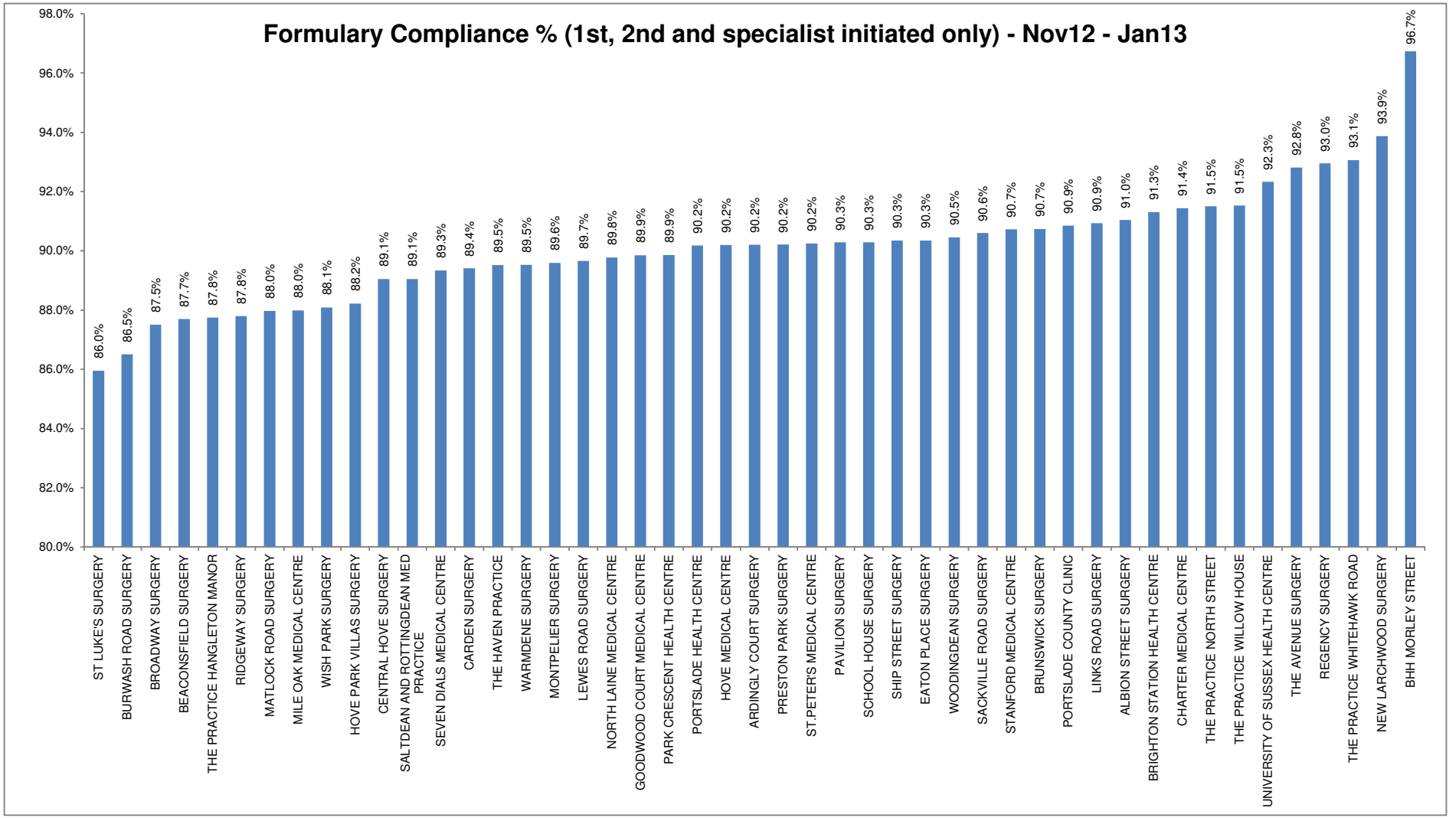
In April 2012, the Brighton and Hove Joint Formulary was launched for use across all health sectors in Brighton & Hove. The purpose was to optimise prescribing through promotion of cost effective drug choice across primary and secondary care, to reduce variation in prescribing practice and to support continuity of care across sectors.

Drugs were included on the basis of current guidelines, historical use, on-going review of evidence of clinical effectiveness, safety and cost.

New drugs are added by agreement of the BSUHT Formulary Committee / DTC and CCG Medicines Management Committee.

The range of drugs included in the formulary should be sufficient to meet the needs of the vast majority of patients, though it is acknowledged that there will be exceptions.

Adherence to the joint formulary will be measured through the Eclipse® software


Formulary Compliance % (1st, 2nd and specialist initiated only) - Nov12 - Jan13
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
80.0%
86.0%
86.5%
87.5%
87.7%
87.8%
87.8%
88.0%
88.0%
88.1%
88.2%
89.1%
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89.3%
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90.6%
90.7%
90.7%
90.9%
90.9%
91.0%
91.3%
91.4%
91.5%
91.5%
92.3%
92.8%
93.0%
93.1%
93.9%
96.7%
ST LUKE'S SURGERY
BURWASH ROAD SURGERY
BROADWAY SURGERY
BEACONSFIELD SURGERY
THE PRACTICE HANGLETON MANOR
RIDGEWAY SURGERY
MATLOCK ROAD SURGERY
MILE OAK MEDICAL CENTRE
WISH PARK SURGERY
HOVE PARK VILLAS SURGERY
CENTRAL HOVE SURGERY
SALTDEAN AND ROTTINGDEAN MED PRACTICE
SEVEN DIALS MEDICAL CENTRE
CARDEN SURGERY
THE HAVEN PRACTICE
WARMDENE SURGERY
MONTPELIER SURGERY
LEWES ROAD SURGERY
NORTH LAINE MEDICAL CENTRE
GOODWOOD COURT MEDICAL CENTRE
PARK CRESCENT HEALTH CENTRE
PORTSLADE HEALTH CENTRE
HOVE MEDICAL CENTRE
ARDINGLY COURT SURGERY
PRESTON PARK SURGERY
ST.PETER'S MEDICAL CENTRE
PAVILION SURGERY
SCHOOL HOUSE SURGERY
SHIP STREET SURGERY
EATON PLACE SURGERY
WOODINGDEAN SURGERY
SACKVILLE ROAD SURGERY
STANFORD MEDICAL CENTRE
BRUNSWICK SURGERY
PORTSLADE COUNTY CLINIC
LINKS ROAD SURGERY
ALBION STREET SURGERY
BRIGHTON STATION HEALTH CENTRE
CHARTER MEDICAL CENTRE
THE PRACTICE NORTH STREET
THE PRACTICE WILLOW HOUSE
UNIVERSITY OF SUSSEX HEALTH CENTRE
THE AVENUE SURGERY
REGENCY SURGERY
THE PRACTICE WHITEHAWK ROAD
NEW LARCHWOOD SURGERY
BHH MORLEY STREET

Lansoprazole 30mg step down

Proposal

Review patients on lansoprazole 30mg daily dose and step down where appropriate:

- Identify patients with a repeat prescription for lansoprazole 30mg.
- Complete the data collection sheet and review, stepping down or stopping as appropriate.

Submit competed data collection sheets and summary sheets by 15/03/2014

Rationale

- PPIs can bring significant benefits to patients with previously intractable GORD, prevent drug induced gastric damage and are useful in the **short term** in other acid-peptic conditions.

- There are, however, concerns regarding the adverse effects of longer term PPI use, particularly at high dose. An increase in the prevalence of pneumonia and *Campylobacter* enteritis is reported; and several studies have concluded that PPI use may be linked to increased risk of *C.difficile* infection. Acute interstitial nephritis and osteoporosis are unusual but recognised consequences of treatment with proton pump inhibitors, and the MHRA has warned of an association with hypomagnesaemia.

- NICE guidance recommends reviewing PPIs taken for dyspepsia at least annually with a view to step down, stopping treatment, or a return to self-care with antacids and/or alginates.

- History of GI ulceration is not an indication for long term high dose PPIs; the dose can be stepped down and/ or stopped according to symptoms once the ulcer has healed.
  For GI cover during NSAID treatment, low dose PPI (lansoprazole 15mg or omeprazole 20mg) is sufficient.

- There are a few conditions where long term high dose PPIs may be appropriate eg oesophageal strictures, Zollinger-Ellison syndrome, alcoholic liver disease, Barrett's oesophagus

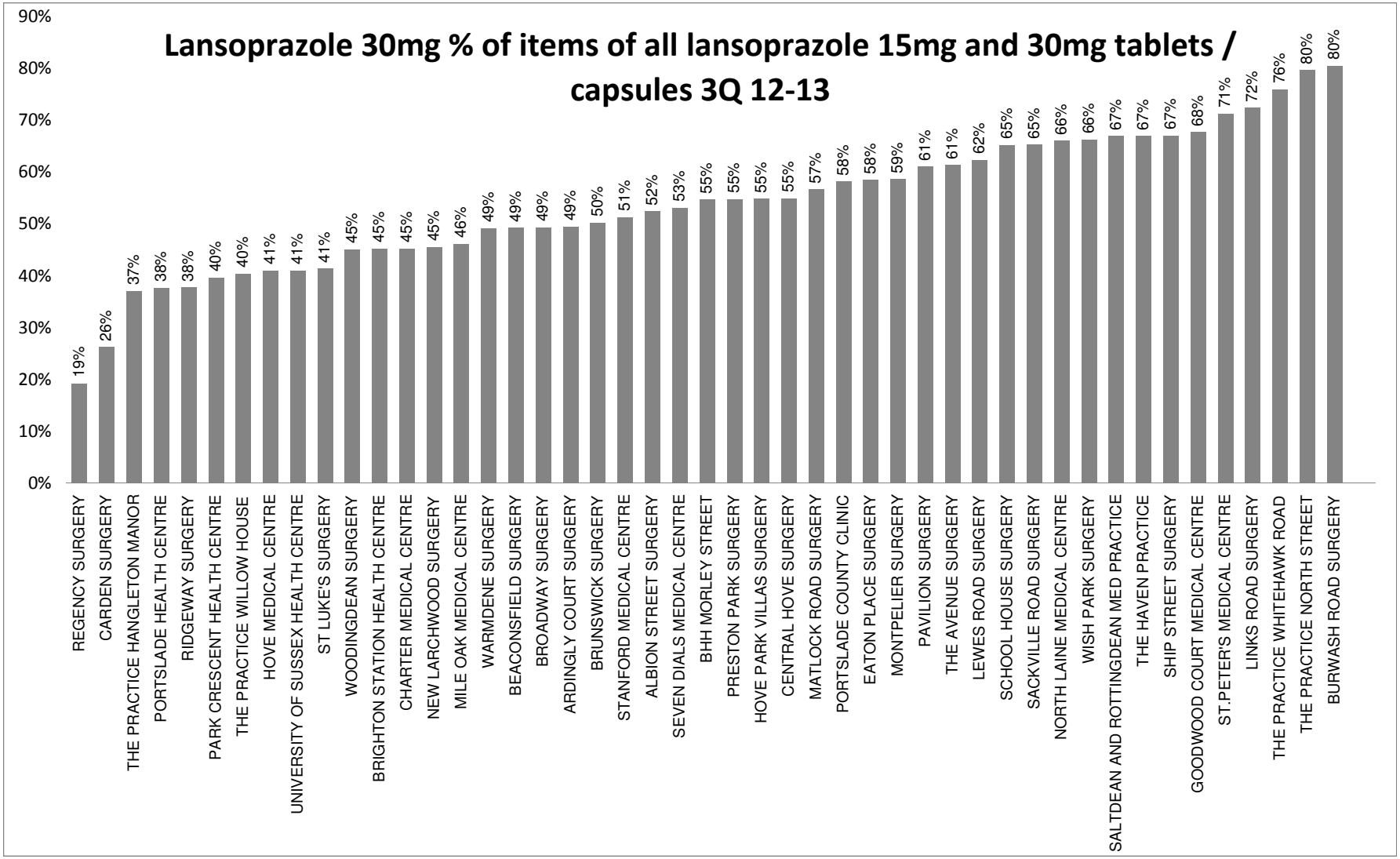
- Locally, over half of the cases of community acquired C.difficile, have not involved broad spectrum antibiotic, but patients were noted to have been taking long term high dose PPIs.
  The recently completed Care Homes project identified scope for large scale stepping down of PPI use.

- Stopping PPIs can sometimes cause rebound dyspepsia; this can often be managed by providing a prescription for short term treatment with an alginate (Peptac is the formulary alginate), and pre-warning patients that this may occur.

- There is significant variation in prescribing of high dose lansoprazole between practices.

References

- Proton pump inhibitors in long-term use: reports of hypomagnesaemia. MHRA Drug Safety Update April 2012
- MaggioM *et al* Proton Pump Inhibitors and Risk of 1-Year Mortality and Rehospitalization in Older Patients Discharged From Acute Care Hospitals JAMA INTERN MED 2013
- NICE guidance (Clinical Guideline 17 Dyspepsia: management of dyspepsia in adults in primary care)


Lansoprazole 30mg % of items of all lansoprazole 15mg and 30mg tablets / capsules 3Q 12-13
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
REGENCY SURGERY 19%
CARDEN SURGERY 26%
THE PRACTICE HANGLETON MANOR 37%
PORTSLADE HEALTH CENTRE 38%
RIDGEWAY SURGERY 38%
PARK CRESCENT HEALTH CENTRE 40%
THE PRACTICE WILLOW HOUSE 40%
HOVE MEDICAL CENTRE 41%
UNIVERSITY OF SUSSEX HEALTH CENTRE 41%
ST LUKE'S SURGERY 41%
WOODINGDEAN SURGERY 45%
BRIGHTON STATION HEALTH CENTRE 45%
CHARTER MEDICAL CENTRE 45%
NEW LARCHWOOD SURGERY 45%
MILE OAK MEDICAL CENTRE 46%
WARMDENE SURGERY 49%
BEACONSFIELD SURGERY 49%
BROADWAY SURGERY 49%
ARDINGLY COURT SURGERY 49%
BRUNSWICK SURGERY 50%
STANFORD MEDICAL CENTRE 51%
ALBION STREET SURGERY 52%
SEVEN DIALS MEDICAL CENTRE 53%
BHH MORLEY STREET 55%
PRESTON PARK SURGERY 55%
HOVE PARK VILLAS SURGERY 55%
CENTRAL HOVE SURGERY 55%
MATLOCK ROAD SURGERY 57%
PORTSLADE COUNTY CLINIC 58%
EATON PLACE SURGERY 58%
MONTPELIER SURGERY 59%
PAVILION SURGERY 61%
THE AVENUE SURGERY 61%
LEWES ROAD SURGERY 62%
SCHOOL HOUSE SURGERY 65%
SACKVILLE ROAD SURGERY 65%
NORTH LAINE MEDICAL CENTRE 66%
WISH PARK SURGERY 66%
SALTDEAN AND ROTTINGDEAN MED PRACTICE 67%
THE HAVEN PRACTICE 67%
SHIP STREET SURGERY 67%
GOODWOOD COURT MEDICAL CENTRE 68%
ST.PETER'S MEDICAL CENTRE 71%
LINKS ROAD SURGERY 72%
THE PRACTICE WHITEHAWK ROAD 76%
THE PRACTICE NORTH STREET 80%
BURWASH ROAD SURGERY 80%

Lansoprazole Step Down

Practice:

Date:

Search for all patients on lansoprazole 30mg daily dose (include patients on lansoprazole 15mg x 2 daily)

Pt ID	Indication (if oesophageal stricture/ Barrett's/ Zollinger Ellison/ alcoholism, do not proceed)	Date started. If < 2 months ago, do not proceed	Tried low dose in last 12 months? If y, do not proceed	Review of lansoprazole dose in last 12 months? If no, refer for review	Action

Lansoprazole step down

Practice	
Practice Lead	
Date	

No. of patients on lansoprazole 30mg daily dose	
No. of patients on 30mg reviewed	
No. where dose reduction was possible	

Please give details of any learning points or actions taken by the practice as a result of this review:

Submit to Medicines Management Team by 15th March 201

Appendix: PIS payment per practice

ASTRO-PUs are an estimate, based on list size data from March 2012 and therefore subject to change

Practice	Total Cost based Astro PUs	Maximum points (targets) to achieve	Maximum payment	Payment per PIS point achieved
ALBION STREET SURGERY	31893	11	£3,556	£323
ARDINGLY COURT SURGERY	37643	11	£4,197	£382
BEACONSFIELD SURGERY	58180	11	£6,486	£590
BHH MORLEY STREET	3598	11	£401	£36
BRIGHTON STATION HEALTH CENTRE	13324	11	£1,485	£135
BROADWAY SURGERY	10521	11	£1,173	£107
BRUNSWICK SURGERY	29793	11	£3,321	£302
BURWASH ROAD SURGERY	13413	11	£1,495	£136
CARDEN SURGERY	34881	11	£3,889	£354
CENTRAL HOVE SURGERY	28455	11	£3,172	£288
CHARTER MEDICAL CENTRE	85890	11	£9,575	£870
EATON PLACE SURGERY	37294	11	£4,158	£378
GOODWOOD COURT MEDICAL CENTRE	47440	11	£5,289	£481
HOVE MEDICAL CENTRE	60176	11	£6,709	£610
HOVE PARK VILLAS SURGERY	22598	11	£2,519	£229
LEWES ROAD SURGERY	13933	11	£1,553	£141
LINKS ROAD SURGERY	32142	11	£3,583	£326
MATLOCK ROAD SURGERY	17005	11	£1,896	£172
MILE OAK MEDICAL CENTRE	41924	11	£4,674	£425
MONTPELIER SURGERY	30806	11	£3,434	£312
NEW LARCHWOOD SURGERY	3793	11	£423	£38
NORTH LAINE MEDICAL CENTRE	18920	11	£2,109	£192
PARK CRESCENT HEALTH CENTRE	55563	11	£6,194	£563
PAVILION SURGERY	47735	11	£5,322	£484
PORTSLADE COUNTY CLINIC	18866	11	£2,103	£191
PORTSLADE HEALTH CENTRE	72879	11	£8,125	£739
PRESTON PARK SURGERY	55336	11	£6,169	£561
REGENCY SURGERY	19735	11	£2,200	£200
RIDGEWAY SURGERY	15695	11	£1,750	£159
SACKVILLE ROAD SURGERY	62243	11	£6,939	£631
SALTDEAN AND ROTTINGDEAN MED PRACTICE	73550	11	£8,200	£745
SCHOOL HOUSE SURGERY	24200	11	£2,698	£245
SEVEN DIALS MEDICAL CENTRE	39322	11	£4,384	£399
SHIP STREET SURGERY	8828	11	£984	£89
ST LUKE'S SURGERY	15812	11	£1,763	£160
ST.PETER'S MEDICAL CENTRE	57150	11	£6,371	£579
STANFORD MEDICAL CENTRE	74175	11	£8,269	£752
THE AVENUE SURGERY	30258	11	£3,373	£307
THE HAVEN PRACTICE	13236	11	£1,476	£134
THE PRACTICE HANGLETON MANOR	12687	11	£1,414	£129
THE PRACTICE NORTH STREET	9096	11	£1,014	£92
THE PRACTICE WHITEHAWK ROAD	14396	11	£1,605	£146
THE PRACTICE WILLOW HOUSE	10180	11	£1,135	£103
UNIVERSITY OF SUSSEX HEALTH CENTRE	31051	11	£3,462	£315
WARMDENE SURGERY	60088	11	£6,699	£609
WISH PARK SURGERY	34678	11	£3,866	£351
WOODINGDEAN SURGERY	39333	11	£4,385	£399