Agenda item: 12 **Paper no: PCCCiC 23-19**

Title of Report:	**NWS CCG - Medicines Optimisation Quality Delivery Scheme**	
Status:	**TO APPROVE**	
Committee:	**PCCCiC Part One**	**Date**: 08/03/2019
Venue:	G&W CCG, Dominion House, Woodbridge Road, Guildford, GU1 4PU	

Presented by:	Karen Thorburn, Managing Director, NWSCCG	
Executive Lead sign off:	Karen Thorburn, Managing Director, NWSCCG	**Date:** 28/02/2019
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Governance:

Conflict of Interest: The Author considers:	None identified	✓
Previous Reporting: (relevant committees/ forums this paper has previously been presented to)	The NWS CCG QDS has been presented at: - NWS CCG MOG (Jan and Feb 2019) - NWS PCOG (Feb 2019)	
Freedom of Information: The Author considers:	Open – no exemption applies	✓

Executive Summary:

The Quality Delivery Scheme (QDS) has operated in NWS CCG to support cost-effective prescribing for GP practices since 2013. The funding for the QDS for 2019/20 has been rolled forward as part of the CCG baseline funding for 2019/20 (payments based on 50 pence per patient).

The QDS is a key tool for engagement for the Medicines Optimisation Team and provides a valuable platform to set out plans to review prescribing over the forthcoming year. In 2018/19 all GP practices actively participated in the medicines optimisation QDS.

The QDS offers a framework to provide engagement with our member practices to support the delivery of cost effective prescribing. The overall payment of £0.50 per patient has not increased since the scheme first started in NWS CCG and the investment by the CCG of approx. £190K to support QIPP delivery for prescribing has remained unchanged. The QIPP savings generated in relation to the primary care prescribing budget for NWS CCG have been in excess of £1m/year for the last 6 years.

The QDS for 18/19 was initially discussed at the NWS CCG MOG. It was agreed that it would be appropriate to continue in a similar format to previous years pending a larger review of the scheme given the introduction of the new contract which states as part of the PCN DES within the Investment and Impact Fund:

***prescribing costs**. NHS England will review past and existing prescribing incentive schemes in 2019 to develop a standard national model.*

This wider NHS utilisation part of the fund will be introduced in a phased way. And unlike many shared savings schemes, the utilisation part of Investment and Impact Fund will not create unfunded risk for either CCGs or hospital contracts. Instead, the funding is pre-identified and capped. The exception to this is the prescribing element, which will be funded through the existing primary care drugs budget and the savings opportunity on prescribing is not therefore capped but will depend on the extent to which networks can achieve greater efficiencies than those already planned by their CCGs.

The NWS PCOG (22nd Feb) supported the proposed medicines optimisation QDS (elements 1-3) but requested a review of element 4 which attributes up to 20p/patient for practices that deliver their primary care prescribing budget with practices that demonstrate movement towards the budget being paid on a graduated scale. PCOG requested consideration of a gain share approach for practices that come under budget in line with the concepts included in the new GP contract (see above). Work is currently being undertaken exploring different options around element 4 which will need to be agreed by PCOG.

Implications:

What is the **health impact/ outcome** and is this in line with the **CCG's strategic objectives**?	• Achieving a sustainable system • Safe, effective care providing the best possible health and care outcomes and patient experience
What is the **financial/ resource** required?	If all elements of the QDS are achieved total payment for the QDS £190K. (payment based on 50p/patient remains unchanged to previous years)
What **legislation, policy or other guidance** is relevant?	Note the new GP contract
Is an **Equality Analysis** required?	Not indicated
Any **Patient and Public Engagement**/ consultation required?	Through the patient representative member of the Medicines Optimisation Group.
Potential **risk(s)**? (including reputational)	Potential disengagement by GP practices to support the CCG in delivering practice prescribing initiatives and thus delivery of the QIPP target

Recommendation(s):

PCCC is asked to approve the NWS CCG Medicines Optimisation Quality Delivery Scheme with Chairs Action for element 4 after agreement by NWS CCG PCOG.

Next Steps:

To offer the medicines Optimisation Quality Delivery Scheme to all practices for sign up by 30th April 2019.

Proposal for Practice Medicines Management Quality Delivery Scheme 2019/20

Proposed scheme 2019/20

1. £600 per practice for a GP prescribing lead representative to attend three prescribing leads meetings during 2019/20.

    - The attending GP should provide a summary and feedback to the practice on key learning points.
    - We encourage additional prescribers / GP Clinical Pharmacists to attend, but please contact MM team to request availability in advance (however payment is per practice attending not per attendee)
    - Please contact your Medicines Optimisation Pharmacist if there is a reason preventing timely attendance on the day.

    Payment will be made per practice after attendance at each meeting.

2. Maximum of 15p/patient to undertake clinical audit to improve the safety of the prescribing of the direct oral anticoagulants (DOACs), dabigatran, rivaroxaban, apixaban and edoxaban, in patients with impaired renal function.

    Anticoagulants are one of the classes of medicines which frequently cause harm and admission to hospital. The National Patient Safety Agency (NPSA) Patient Safety Alert number 18, March 2007 advised healthcare organisations to take steps to manage the risks associated with the prescribing, dispensing and administering of anticoagulants. One of the key messages of this alert was for GPs to carry out an annual audit of anticoagulant services. One advantage of DOACs over warfarin is that they do not require monitoring of clotting parameters with consequent dosage adjustment as they are given as fixed once or twice daily regimes. However they are all dependent on the kidney for excretion and may require dose modification depending on the patient's renal function. Incorrect dosing may lead to increased bleeding and/or failure to achieve the level of stroke risk reduction for which the DOAC was prescribed.

    Practices are required to:

    A) Undertake a clinical audit to review the prescribing and monitoring of DOACs in patients with impaired renal function which will include
    - To check whether appropriate dose adjustments have been made for patients with renal impairment who are prescribed a DOAC.
    - To determine whether the recommended dose adjustments (according to the SPC) have been made where restrictions apply.
    - To identify patients on a DOAC who have not had a renal function test in the past 12 months.

    AND

    B) Provide the completed audits and a reflective summary of learning by 31st March 2020

    The audit templates and supporting materials will be provided by the Medicines Optimisation Team. All patients being prescribed a DOAC must be included in the audit. The search method identifies all patients taking a DOAC and will highlight patients with an eGFR of 60 or below in the past 12 months as well as those who have not had a renal function test in the last 12 months.

3. Maximum of 15p/patient for **ASTHMA** reviews of a patient group to minimise adverse drug reactions (ADR) caused by prolonged use of high dose ICS (Inhaled Corticosteroids).

Review of High Dose Inhaled Corticosteroids (ICS) in patients with asthma:

Rationale

Inhaled corticosteroids (ICS) are the first-choice regular preventer therapy for adults with asthma for achieving overall treatment goals. To minimise side effects from ICS in people with asthma, the BTS/SIGN guideline on the management of asthma recommends that the dose of ICS should be titrated to the lowest dose at which effective control of asthma is maintained.

The BTS/SIGN guideline on the management of asthma recommends that reductions in ICS dose should be considered every 3 months, decreasing the dose by approximately 25–50% each time. Data suggest that this is realistic and possible without compromising patient care. The guideline states that stepping down therapy once asthma is controlled is recommended, but often not implemented, leaving some people over-treated.

Epact2 Respiratory Dashboard data for November 2018 shows that NWS are outliers in the prescribing of high dose ICS as a percentage of total ICS item prescribing in comparison to CCGs nationally, regionally and those classed in the similar 10. There is a wide variation of high dose ICS prescribing, across the practices, within NWS CCG.

Within QOF, practices are only required to ask the three RCP questions to assess asthma control. This audit requires patients with a score of 0 on the three RCP questions to be considered for review and stepping down. Those who are considered suitable for stepping down may be reviewed as part of their annual review, should be offered a personalised asthma action plan and a steroid treatment card if they are to continue on a high dose ICS.

This review will also highlight non-formulary prescribing and prescribing of inhalers using unlicensed doses.

Practices are required to:

A) Undertake a clinical audit to review the prescribing of high dose ICS (included within the Epact2 Respiratory dashboard and as defined in the BTS/SIGN guidelines) in patients 18 years and over with a READ code diagnosis of ASTHMA. All asthma patients on a high dose ICS showing good asthma control, for at least 3 months, should be considered for stepping down i.e. patients with a score of 0 on the three RCP questions. Those who are considered suitable for stepping down may be reviewed as part of their annual review, should be offered a personalised asthma action plan and a steroid treatment card if they are to continue on a high dose ICS.
    - *Patients with other respiratory conditions such as COPD, patients under specialist respiratory care, patients who have been reviewed in the last 3 months and stepping down has been excluded, palliative patients, currently pregnant, and those who have had a recorded exacerbation in the last 12 months will be excluded*. *Any patient receiving maintenance and reliever therapy (MART) with a combination ICS and long acting beta agonist (LABA). Symbicort 100/6, Symbicort 200/6, Fostair 100/6, Fostair NEXThaler 100/6 or DuoResp Spiromax 160/4.5 will also be excluded.*

AND

B) Provide the completed audits and a reflective summary of learning by 31st March 2020 The audit templates and supporting materials will be provided by the Medicines Optimisation Team. All patients identified for consideration of stepping down should be reviewed, however those who do not attend for a review appointment may be excluded.

4. 20p/patient for practices that deliver their primary care prescribing budget. For practices that demonstrate movement towards budget payment will be made as follows:
   - A reduction in % overspend for 19/20 by 75% or more compared to % overspend for 18/19 = 15p /patient
   - A reduction in % overspend for 19/20 by between 50% and 74% compared to % overspend for 18/19 = 10p / patient
   - A reduction in % overspend for 19/20 by between 25% and 49% compared to % overspend for 18/19 = 5p / patient