NORWICH CCG PRESCRIBING QUALITY SCHEME (PQS) 2019/20

1.	Introduction
1.1	**Scheme** This scheme builds on previous years' schemes and aligns with the National, STP and CCGs' Quality, Innovation, Productivity and Prevention (QIPP) agenda. **Purpose of the scheme:** to encourage and reward cost-effective and high quality prescribing. Incentives are available to reward improvements in patient care and efficient use of resources. The scheme does not simply reward low cost prescribing, but includes criteria relating to the improvement in quality of prescribing. **Principles:** • To support financial stability and make best use of resources without compromising patient care. • To encourage practices to consider how patients can be supported to get the best from their medicines, and how they can benefit from cost effective quality prescribing. • Incentives should reward improvements in patient care and efficient use of resources. It is therefore important that the scheme does not simply reward low cost prescribing, but should include criteria relating to the quality of the prescribing.
1.2	**Eligibility to participate in the scheme:** The scheme will be available to all practices. **Participation is *voluntary*: Practices may elect to do part ONE and /or part TWO.**
1.3	**Payment**: A maximum payment of **80p per patient** (based on Q3 19-20 practice list size) may be achieved. *See Appendix 5 for approved uses of Quality Scheme Payment.*
1.4	**Summary:** The Scheme will be run from **April 2019 to March 2020** Payment will be split: Total **50p per patient** for **savings** and **30p per patient** for **TWO quality reviews** and **ONE education module.** **Payments will only be awarded if achievement has been maintained to the end of Q4**. ***Significant*** *list size changes and any other extenuating circumstances will be taken into consideration*
1.5	**Support:** AGEM CSU Medicines Optimisation Team (MOT) will support GP practices in identifying savings and recommendations for reviews. The team will also provide ongoing monitoring and advice with respect to reviews and resultant action plans. **The MOT will *not* undertake the work on the specific focus areas and reviews within the PQS on behalf of the practices.**
1.6	**Exception reporting** Practices may exception report if there is a clear auditable reason e.g. patient is already being looked after by a specialist prescriber.

2. The Prescribing Quality Scheme

Timescale	Required Activity and Measurement		Payment per patient (based on Q3 2019-20 list size)	Total Payment Available
Part ONE	**Medicines Optimisation Savings**			
Apr 2019-Mar 2020	***Minimum* FOUR specific focus areas** **See: *Appendix 1* for *suggested topics*.** *Not all are included in the savings target, but all will lead to a reduced spend / AstroPU*	**Cumulative % change for last year –** *lower than the national*	**10p** if achieved by the end of **Q4**	**50p** per patient on list size
		Spend per AstroPU (annualised) *lower than March 2019 figure* ***OR*** *lower than CCG average but no higher than March 19 figure*	**10p** if achieved by the end of **Q4**	
		At least 50% achievement of the Practice's *savings target* *(detailed breakdown in separate document)* ***Reporting on achievement available from July 2019*** *(April data available late June): Savings target and savings to date and will be stated in* ***monthly 19-20 Prescribing Monitoring Report***	**20p** if **achieved by the end of Q2** and maintained to the end of Q4	
			10p if **achieved by the end of Q3** and maintained to the end of Q4	
			5p if **achieved by the end of Q4**	
			Additional 10p on top of the achievement above **if 70% or more achieved by the end of Q4**	
30th Apr 2020	**Submit a summary of work done towards achieving the savings.** *Use action plan Appendix 2 and email to* pauline.shead@nhs.net			
Part TWO	**Medication Reviews and Education Module**			
Apr 2019-Mar 2020	**Medication Reviews**	**Select TWO of the following:** • **Polypharmacy reviews** with a *suggested* focus on Type 2 Diabetes newer oral hypoglycaemic drugs • **Review of patients with COPD triple therapy** (cannot choose if in NCCG LCS) • **Review of DOAC prescribing and appropriate monitoring** • **NRAD** (National Review of Asthma Deaths) • **Review of patients on strong opioids *PLUS other analgesics*** • **Review of Anxiolytics and Hypnotics**	**20p** for completion **by the end of Q4**	**20p** per patient on list size
Apr 2019 – Sept 2019	**Education module** *See Appendix 4*	**AND *each prescriber* must select ONE of the following:** • Polypharmacy & de-prescribing • Reducing opioid prescribing in chronic pain	**10p** for evidence of completion **by end of Q2.**	**10p** per patient on list size
31st Oct 2019	**Submit evidence that all prescribers employed by the practice have completed one of the education modules *plus brief feedback on the modules*.** pauline.shead@nhs.net			
30th Apr 2020	**Submit a summary and action plan for each review.** See *Appendix 3* for more details pauline.shead@nhs.net			

Appendix 1: Quality, Innovation, Productivity & Prevention (QIPP) - Suggested Medicines Optimisation Topics for 2019-20

Clinical Area	Aligned Topic	Area	Key Message	Resource
Respiratory	**1a. COPD**	**Inhaled Corticosteroid (ICS) /Long Acting Beta Agonist (LABA) + triple therapy combinations**	Cost effective choice of inhaler device. Ensure all generic combined ICS prescribed as brand	COPD Formulary
Respiratory	**1b.COPD**	**COPD management review - Triple therapy**	Review COPD TT patients and consider stepping off ICS and switching to LAMA / LABA combo (ensure not asthma patients). If to appropriate to remain on TT switch to cost effective option (Trimbow® or Trelegy®)	AGEM Searches and review tool. PCRS Triple Therapy step down tool. Local COPD guidance / pathway.
Respiratory	**1c.COPD**	**Long Acting Muscarinic Antagonists (LAMAs)**	Cost effective choice of LAMA. First choice: Braltus® 10mcg (tiotropium)	COPD Formulary
Respiratory	**1d. Asthma**	**Asthma management / β- agonist overuse**	Review and step high dose ICS where possible and β-agonist overuse patients. Identify and review LABA only treatment.	PrescQIPP NRAD search tool and audit on
Respiratory	**1e. COPD & Asthma**	**Inhaler technique**	Ensure all clinical and dispensary staff competent to demonstrate and check patients inhaler technique - consider setting up placebo inhaler box. Patients have inhaler technique checked at review.	UK inhaler group 'inhaler standards and competency document'.
Respiratory	**1f. COPD & Asthma**	**Targeted Medicine Usage Reviews (MUR)**	Work with local Community Pharmacy to set up targeted MURs and develop referral pathway	
CNS	**2a. MH**	**Quetiapine**	Prescribe plain generic quetiapine instead of slow release preparations	Key Message Bulletin 16: Quetiapine MR to IR
CNS	**2b. MH**	**Methylphenidate XL tablets**	Cost effective choice in agreement with NSFT	Shared Care Agreement: Stimulants for ADHD
CNS	**2c. MH**	**Hypnotics and anxiolytics**	Develop a practice policy and review prescribing	AGEM hypnotics review tool, patient letters, PrescQIPP bulletins

Clinical Area	Aligned Topic	Area	Key Message	Resource
CNS	**2d. MH (DLCV)**	**High-cost / low clinical value antidepressants**	Review all dosulepin / trimipramine for possible switch (in an appropriate way) to safer /cost effective choices - if still required.	PrescQIPP bulletins
CNS	**3a. Pain**	**Buprenorphine patches**	Review long term patients and step off where possible, audit and change practice. No new patients unless swallowing difficulties.	Audit / medication review tool. Pain Formulary. Key message Bulletins 35, 14 & 15 Opioid treatment agreement Pain diary Patient info leaflet on reviewing opioids
CNS	**3b. Pain**	**Cost effective Buprenorphine patches**	Where appropriate, prescribe as cost effective choice; Butec®, Reletrans® or Sevodyne®.	
CNS	**3c. Pain**	**Fentanyl patches**	Review long term patients and step off where possible, audit and change practice.	
CNS	**3d. Pain**	**Cost effective Fentanyl patches**	Where appropriate, prescribe as cost effective - Matrifen®, Mezolar® Matrix or Fencino®	
CNS	**3e. Pain**	**Cost effective tramadol**	Prescribe generic plain no MR	
CNS	**3f. Pain**	**Oxycodone**	Reduction in use. Where appropriate use cost effective choice.	
CNS	**3g. Pain / DLCV**	**Neuropathic pain**	Review of lidocaine patch and co-prescribed drugs for neuropathic pain.	Neuropathic pain pathway
Infections	**4a. AMS**	**Broad spectrum Antibiotics: Cephs, Quins and co-amoxiclav**	Reduce prescribing of high-risk C diff antibiotics	Key Message Bulletin 34. AGEM Audit of broad spectrum antibiotic against formulary.
Infections	**4b. AMS**	**Clinical audits**	Appropriate antibiotic prescribing. Reduction in overall volume.	RCGP TARGET Antibiotic Tookit audits and resources.
Infections	**4c. AMS**	**Antibiotic Campaign**	Run a campaign in the practice	PHE Campaign resources.
Endocrine	**5a. Diabetes**	**Insulins**	Human NPH insulin first choice	Key Message Bulletin 17

Clinical Area	Aligned Topic	Area	Key Message	Resource
Endocrine	**5b. Diabetes**	**BGTS**	Cost effective choice and appropriate use / volume	Key Message Bulletin 22. Cost comparison chart. Review tool.
Endocrine	**5c. Diabetes**	**Lancets and needles**	Cost effective choice	Key Message Bulletin 23 &24
Endocrine	**5d. Diabetes**	**Biosimilar insulin**	Use biosimilar insulin first line	T2DM insulin pathway
Endocrine	**5e. Diabetes**	**Insulin Quantities**	Ensure all insulin quantities on repeat prescriptions are appropriate for dose to reduce stockpiling and waste. Audit tool, quantities table and calculator available.	AGEM review tool and calculator
Endocrine	**5f. Diabetes**	**High-risk Hypo reviews**	Review patients at risk of hypoglycaemia to reduce admissions	Dr Clare Hambling *Choosing Wisely* hypo guidance
Endocrine	**5g. Diabetes**	**GLP -1 mimetics**	Review use and effectiveness of GLP-1s.	AGEM Review tool
Endocrine	**5h. Diabetes**	**DPP4-inhiptors (Gliptins)**	Review use and effectiveness of DPP4- inhibitors. Consider alogliptin first line for new patients.	AGEM Review tool
Endocrine	**5i. Diabetes**	**SGLT2 s**	Review use and effectiveness of SGLT2s	AGEM Review tool
Endocrine	**5j. Diabetes**	**Management of Freestyle Libre**	Specialist use in line with national commissioning pathways	
DLCV	**6. Various**	**As per NHSE**	Review of 17 products not routinely to be prescribed in primary care	PrescQIPP bulletins NHSE guidance
Self Care	**7. Self-Care**	**Vitamins & Minerals**	Target quick wins such as Vitamin B. low dose vitamin D, multi-vitamins, ascorbic acid etc.	NHSE & CCG Self-care guidance
Self-Care	**7. Self-Care**	**Self-Care Campaign**	Run a campaign in the practice	Self-care forum and PrescQIPP resources
Self-Care	**6. Self-Care**	**Self-Care liaison with local pharmacy**	Work with local pharmacy to ensure self-care treatment pathways are workable	Self-care referral pads

Clinical Area	Aligned Topic	Area	Key Message	Resource
Poly-pharmacy reviews	**8. Medication Review**	**Medication review of the highest risk frail patients 2-3% as agreed with the practice.**	Thorough clinical medication review. Making savings and preventing admissions.	Medication review template. Deprescribing algorithms - bisphosphonates, PPIs, statins, anticholinergics - OABs, Dr Clare Hambling *Choosing Wisely* hypo guidance, Hypoglycaemics - GLP-1s, SGLT2s, DDP4s. STOPPFrail tool
CVS	**9a. Anti-coagulants**	**Cost Effective choice of DOACS**	Prescribe Edoxaban first-line to maximise CCG rebate. Switch rivaroxaban / apixaban / dabigatran to edoxaban where dose reduction required.	Local guidance. Review tool.
CVS	**9b. Nitrates**	**Cost effective nitrates**	Switch all expensive branded and generic XL 60mg to cost effective brand; Monomil® XL, Tardisc® XL or Chemydur® XL. Switch plain all strengths / preparation to cost effective XL 60mg brand	
Eyes	**10a. Dry eye**	**Tear Deficiency and eye preps**	Prescribe cost effective choice - review against formulary/dry eye pathway. Encourage self-care.	Dry eye pathway and formulary. Key Message Bulletin in development
Eyes	**10b. Glaucoma**	**Glaucoma - branded to generic**	Prescribe PDEis and betablockers generically	
NSAID	**11a. Pain**	**Low risk NSAID**	Review all high risk NSAID patients for switch to ibuprofen or naproxen	AGEM Audit tool
NSAID	**11b. Pain**	**Cost Effect NSAID**	Review and switch all expensive NSAID to cost effective options	
Nutrition	**12a.**	**Oral Nutritional Supplements**	Review patients - use appropriate product shakes vs sip. Switch to Altraplen compact where sip feed indicated. Appropriate prescribing in care homes. Audit tool available. Malnutrition risk assessment template available. *Joint working with dietitians to be developed re. Care home training.*	Formulary and ONS pathway. Fortified feast booklet. Care Home Best Practice Bulletin Malnutrition for carer's document. Audit tool.

Clinical Area	Aligned Topic	Area	Key Message	Resource
Nutrition	**12b.**	**Baby Milks**	Use cost effective product and review length of treatment / dietician involvement	Key Message Bulletins 26.27, 28,&36
Nutrition	**12c.**	**PKU Foods**	Prescribe in line with guidance re. quantities	Local guidance
Nutrition	**12d.**	**Gluten free**	Stop prescribing gluten free foods	
Skin	**13a.**	**Emollients**	Cost effective choice and appropriate use / amounts. Stop bath and shower products.	Formulary and quick guide emollient pathway
Skin	**13b.**	**Emollients**	Stop prescribing in care homes and for anyone with no diagnosed skin indication	Care Home Best Practice Bulletin
Skin	**13c.**	**Barrier creams**	Appropriate use and cost effective choice	Red bottom pathway - *in development*
Skin	**13d.**	**Lymphoedema and Venous Ulcer garments**		Formulary - *in development*
Stoma	**14**	**Cost effective choices / reduce over ordering**	Review patients with Stoma nurse to ensure best practice / targeted switches	Key Message Bulletins 19, 20 & 21 - accessory switch list, patient letters.
Urology	**15a. Continence**	**Bladder Stability Drugs**	Prescribe plain oxybutynin / tolterodine first line. Review effectiveness of treatment and stop.	Bladder stability pathway Review tool and patient letters
Urology	**15b. Continence**	**Continence Appliances**	All Prescribing to be in line with continence formulary for new patients. Consider; Quantities on script, need for catheter, catheter switch, cost effective bags and anaesthetic gel switch.	Formulary and guidance. Key Message Bulletin 42
Urology	**15c. Appliance DROP list**	**Anal irrigation**	Prescribe in line with agreed pathways	
Switches	**16**	**List of housekeeping switches**	Switch to more cost effective option (Incl. generic savings)	Monthly Eclipse reports

Appendix 2: Action plan template to evidence work completed towards achieving medicines optimisation savings

Complete brief details using the table below. **To be submitted to pauline.shead@nhs.net by 30th April 2020**

Practice Name:

Clinical Area	**Specific Topic** *(minimum FOUR)*	**Summary of actions completed**

Appendix 3: Medication Reviews / Audits

Signposting / resources/ support with running searches available if required

1. Polypharmacy reviews

Suggested focus on Patients with Type 2 Diabetes on newer oral hypoglycaemic drugs i.e. GLP-1s *e.g. exenatide*, DPP-4s (gliptins) *e.g. alogliptin*, SGLT2s *e.g*. *dapagliflozin* to ensure in line with NICE.

See **local** Diabetes Formulary and **Key Message Bulletin 8** Medicines Optimisation of Hypoglycaemic Agents

Suggestions for patient groups to search in.

- Polypharmacy Patients – e.g. 10 or more medications
- Older age
- Admission Avoidance register
- Frailty
- Right-Care or clinical group of patients i.e. respiratory, CVS, diabetes, dementia etc.

Requirements

- Using above categories to search in , identify patients to review –**minimum 0.3% of practice list size** *e.g. list size 10,000 patients – number of patients to review = 30*
- Identified patients could have read code as ‘**‘Eligible for Polypharmacy Medication Review’ (Xaccv or 9NgzK) added to their record.**
- **Review all patients selected by end of March 2020.**
- **For all repeat medications,** suggested things to check:
    - appropriate, evidenced based and linked to a current indication
    - clinically effective and still required.
    - any adverse effects
    - any monitoring is up to date and appropriate
    - dose and directions are appropriate
    - concordance
    - formulary / cost effective choice, if appropriate
- Ideally use a medication review template to record interventions
- Read code completion using **polypharmacy review** conducted or similar
- Record brief summary of action(s) taken for each patient i.e. *drugs stopped, dose reduced etc.*
- **Send a summary report* to pauline.shead@nhs.net by the end of April 2020 to claim payment.**

Summary report to the include number of patients reviewed, anonymous brief summary of actions and a general practice action plan related to polypharmacy and how to improve prescribing / reviews.

2. Review of patients with COPD triple therapy

COPD resources available via
https://nww.knowledgeanglia.nhs.uk/KMS/Norwich/Home/Prescribing,PharmacyandMedicinesOptimisation/ClinicalAreas/Respiratory.aspx

Requirements

- Via practice clinical system searches, establish patients who have a read code for / are on the COPD register and have a current repeat template including 'Triple Therapy' (ICS +LAMA+LABA). *Remember patients may be on single inhalers, single + dual inhalers or a triple therapy inhaler.*
- **Review all patients found by the end of March 2020** to ensure Triple Therapy is appropriate using local / national guidelines.
    - **Ensure all patients have been offered** smoking cessation support, pulmonary rehabilitation , flu vaccine and pneumococcal vaccine, where appropriate
    - **If triple therapy is not considered necessary** (use local guidelines), consider stepping down ICS. Primary Care Respiratory Society (PCRS) document available. *Seek specialist advice if needed*
    - **If triple therapy is appropriate**, consider changing to a single triple therapy inhaler device, *unless already using one.*
    - **Ensure all patients have a self-management plan in place.**
- Record action(s) taken for each patient.
- **Send a summary report* to pauline.shead@nhs.net by the end of April 2020 to claim payment.**

**Summary report to include number of patients reviewed, anonymous brief summary of actions for each patient and a practice action plan* related to any improvements required in the management of patients with COPD

3. Review of Direct Acting / Non-vitamin K Oral Anticoagulant (D/NOAC) prescribing and appropriate monitoring

Requirements

- **Search for all patients with a D/NOAC on repeat.**
- **For all patients identified check**
    - medication and dose are correct for indication and patient *(Ensure appropriate dosage adjustment with weight, renal impairment, drug interactions or age)*
    - appropriate baseline monitoring was documented
    - no contra-indications to D/NOAC
    - patient has had a review *at least* within the last 12 months
    - those on additional anti-platelets have a documented reason and follow up.
    - Remember – for AF, if a D/NOAC is appropriate, Edoxaban is the local first line choice, *if suitable for the patient.*
      See Norfolk & Waveney Oral Anticoagulant Therapy in AF July 2018
- **For patients who need any of the above amending or completing – ensure the patients are reviewed by the end of March 2020**
- Record action(s) taken for each patient who is identified as needing a review.
- **Send a summary report* to pauline.shead@nhs.net by the end of April 2020 to claim payment.**

****Summary report to include number of patients needing a review and reasons, anonymous brief summary of actions for each patient and a practice action plan* related to any improvements required in the management of patients with on D/NOACs**

4. **NRAD** (National Review of Asthma Deaths) **review**

See: Why Asthma still kills (2015)

Norfolk & Waveney CCGs Asthma Primary Care Guideline

https://nww.knowledgeanglia.nhs.uk/KMS/Norwich/Home/Prescribing,PharmacyandMedicinesOptimisation/ClinicalAreas/Respiratory.aspx

Aim: To optimise prescribing and medicines use in asthma patients and ensure the key actions in the NRAD report are actioned to reduce risk of death from asthma.

Requirements

- **Search for patients in the *following NRAD groups* PLUS adults with an asthma diagnosis who have high dose ICS inhalers on repeat.**
  NICE NG 80 for adults, high dose:
  https://www.nice.org.uk/guidance/ng80/resources/inhaled-corticosteroid-doses-pdf-4731528781

Beclometasone dipropionate:	1200 – 2000mcg / day
Extra fine beclomethasone dipropionate:	500 – 800mcg/day
Budesonide:	1000 – 1600mcg/day
Fluticasone propionate:	600 – 1000mcg/ day
Fluticasone furoate:	200mcg / day
Ciclesonide:	400-640mcg / day
Mometasone furoate	> 400mcg / day

Title	Age range	Diagnosis	Drug	Search	AND	OR
Poor inhaler technique or no inhaler technique	Any	Asthma or COPD	All inhalers	Poor inhaler technique recorded in last 12 months	-	No inhaler technique assessment recorded
Exacerbating	Any	Asthma	Any	Asthma exacerbation/ attack in the last 12 months	Hospital admission, a and e or OOH	
Very High SABA use	Any	Asthma	Salbutamol inhaler (including all brands) Terbutaline inhaler (including brands	12 or more inhalers prescribed in last 12 months		
High SABA	Any	Asthma	Salbutamol inhaler (including all brands) Terbutaline inhaler (including brands	7 or more inhalers prescribed in last 12 months		
LABA alone in asthma	Any	Asthma	Salmeterol Formoterol Bambuterol (All including brands but excluding compound preparations)	On active repeat prescription (and being issued)	NO concurrent prescribing of inhaled corticosteroid-single products (exclude compound preparations)	
Oral steroid course	Any	Asthma	Prednisolone oral tablets	A least 1 course prescribed in the last 12 months.		
Asthma self-management plan*	Any	Asthma		NOT Issued with a self management plan in the last 12 months.		Self management plan not documented
Inhaled corticosteroid use	Any	Asthma	All inhaled corticosteroids including combination products with LABA	Less than 12 prescriptions in the last 12 months		

Refn: https://www.prescqipp.info/our-resources/bulletins/bulletin-83-asthma-focus/

- Number of patients to review: **at least 0.3% of practice list size** e.g. list size 10,000 patients – number of patients to review = 30 **OR all patients found if less than 0.3% of list size.**
- **Review all patients selected by end of March 2020.**
- **For each patient, record what action is required.**

Some suggested actions include:

For each patient, record what action is required. Some suggested actions include:
If incorrect diagnosis recorded, then read code diagnosis.
If no review within the last 12 months, review patient.
If inhaler technique has not been checked, review patient.
If patient on high dose inhaled corticosteroid with no documented evidence of step down attempted in last three months, review patient and step down if clinically appropriate.
If patient using less than approriate number of ICS or ICS/LABA inhalers in the last 12 months, review patient and consider suitability for stepping down ICS or whether they are adhering to their preventer therapy.
If patient not using SABA, consider suitability for stepping down inhaled corticosteroid.
If patient has used more than 12 SABA inhalers in the past 12 months, urgently review patient as asthma may not be controlled. Also consider urgent review for patients using more than 7 SABA inhalers in last 12 months.
If patient is on a separate ICS inhaler and LABA inhaler, review patient and prescribe ICS / LABA combination inhaler if both components are required and product is licenced for age of patient.
If patient is experiencing side effects, review treatment and consider stepping down dose (a risk vs. benefit assessment will be needed).
If patient has required more than 2 courses of steroids in the previous 12 months or at step 4 or 5 of BTS and **NOT** been referred to a specialist asthma service, make referral.

- **Send a summary report* to pauline.shead@nhs.net by end of April 2020 to claim payment.**

***Summary report to the include number of patients reviewed, anonymous brief summary of actions and a general practice action plan* related to any improvements required in the management of patients with asthma**

5. Review of patients on strong opioids *PLUS other analgesics*

See local Non-malignant pain formulary and **Key Message Bulletins**: Non- Malignant Chronic Pain Management (Adults), Use of Opioids in Non-Malignant Chronic Pain, Tapering opioids for Non-Malignant Chronic Pain

PrescQIPP: https://www.prescqipp.info/our-resources/bulletins/bulletin-218-reducing-opioid-prescribing-in-chronic-pain/

Aim: To identify adults prescribed regular strong opioids PLUS other analgesics *for non-cancer pain*. To review prescribing to assess whether it is appropriate and whether any of the analgesics can be tapered or stopped.

Requirements

- Search for all adult patients with strong opioids on repeat. Search for all adult patients with any other analgesic medication on repeat (including gabapentinoids). Find a list of patients in both search groups *i.e. prescribed both strong opioids AND other analgesics*. **Exclude cancer/palliative care patients.**
- Number of patients to review: **at least 0.3% of practice list size** *e.g. list size 10,000 patients – number of patients to review = 30* ***OR all patients found if less than 0.3% of list size.***
- **Review all patients selected by end of March 2020.**
- **Send a summary report* to pauline.shead@nhs.net by end of April 2020 to claim payment.**

Summary report to the include number of patients reviewed, anonymous brief summary of actions and a general practice action plan related to any improvements required in the management of patients with chronic non-malignant pain.

6. Review of patients prescribed anxiolytics and hypnotics

See PrescQIPP for more details and support documents https://www.prescqipp.info/our-resources/bulletins/bulletin-175-hypnotics/

Prescribing of these drugs is widespread but dependence and tolerance occur. This may lead to difficulty in withdrawing the drug after the patient has been taking it regularly for more than a few weeks. Hypnotics and anxiolytics should therefore be reserved for short courses to alleviate acute conditions after causal factors have been established.

Aim: To raise awareness of current benzodiazepine prescribing and management of misuse and to improve practice in benzodiazepine prescribing. To raise awareness of good sleep hygiene. To identify patients where intervention, to reduce prescribing or facilitate withdrawal, may be recommended.

Requirements:

- **Search for all patients with an anxiolytic/hypnotic on acute/repeat in last 6 months.**
- **For all patients identified check**
    - age of patient
    - medication and dose are correct for indication (anxiety or insomnia)
    - appropriate length of treatment for indication
    - evidence at initiation of discussion of alternatives and potential for dependence
    - evidence of annual medication review if > 4 weeks treatment
    - if more than one hypnotic is prescribed, evidence of regular review

- **Review all patients selected by end of March 2020.**
- **Send a summary report* to pauline.shead@nhs.net by end of April 2020 to claim payment.**

Summary report to the include number of patients reviewed, anonymous brief summary of actions and a general practice action plan related to any improvements required in the management of patients taking anxiolytics/hypnotics.

Appendix 4: Education Modules

These are available via https://www.prescqipp.info/ - see the relevant flyer for more detailed information. All prescribers will need to register for free using their nhs.net email address to enable access to the e-learning resources.

ALL prescribers, including non-medical will be required to **complete ONE of the** following **by the end of September 2019.**
Submission of **evidence of completion** should be emailed to **pauline.shead@nhs.net** **by the end of October 2019.** ***Please also include brief feedback on how useful this was as this is the first time we have used these education modules***

Access to the following courses is being arranged for all GP Practices

Polypharmacy and Deprescribing

Full course: designed for non-medical prescribers and trainee GPs.

A full length course designed for non-medical prescribers and trainee GPs. The course covers the concepts of polypharmacy and deprescribing, describes when polypharmacy may be appropriate or inappropriate and how this occurs. It provides practical advice on the initiation of medicines including shared decision-making with patients.

The course is split into nine bite sized modules to enable you to take the course at your own pace and speed and takes approximately three and a half hours in total. A CPD certified certificate is available upon on completion of the course which requires a pass mark of 80% in the final assessment

Concise course: designed for GPs and more experienced healthcare professionals with some knowledge of the issues.

The course includes modules on the background to deprescribing; multimorbidity; frailty; shared decision making and medication review.

The concise course is split into six modules of less than ten minutes each, four case studies and a final assessment. A CPD certified certificate is available when the final assessment is passed with a mark of at least 70%, and which can be taken up to three times

Reducing opioid prescribing in chronic pain

The course will help equip healthcare professionals to tackle the growth in opioid prescribing and improve care for patients with chronic pain.

The course includes contributions from Dr Ruth Bastable, a GP with experience of working in health care of patients who are homeless and at risk of homelessness and health care of patients in secure environments. Ruth has an interest in substance misuse, and an interest in prescription drug misuse.

This course should take approximately 3 hours. You'll need to complete all the modules and get at least 70% in the final assessment to pass the course, but you can attempt it up to three times. You'll also need to get 60% in each of the quizzes before you can move on to the next lesson, but you can retake these as many times as necessary.

Appendix 5: Approved Uses of Quality Scheme Payment.

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 Quality 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.

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