Summary
Harrogate and Rural District CCG is continuing to offer a prescribing incentive scheme to all its member NHS GP practices as encouragement and reward to improve the quality, safety and cost effectiveness of prescribing. This is one of many elements to enhance the quality and cost effectiveness of prescribing within the area and successful implementation will deliver benefits in 2019/20 and subsequent years. Payments of up to £0.30 per head of practice list size will be made to individual practices based on their achievement against stated prescribing measures, each contributing to a potential maximum cumulative award of 100%.

Financial savings to the CCG prescribing budget are estimated at £117K per annum from these measures alone. This could be exceeded by greater and earlier achievement. If all practices achieved the thresholds to merit maximum awards the CCG’s total pay-out would be £50K. It is possible that not all practices will achieve this and a total award of £35-40K is more realistic. However, if achievement is higher, then the additional payment will be exceeded by the greater savings in the prescribing budget.

Aim
The aims of this document are:
- to describe aims of the 2019/20 prescribing incentive scheme
- to define the content of the 2019/20 prescribing incentive scheme
- to ensure the CCG Governing Body (GB), Senior Management Team, GP practices and the Local Medical Committee are aware of the scheme and its content.

Background
Prescribing measures were removed from the national Quality and Outcomes Framework for 2013/14. As an alternative, prescribing incentive schemes allow CCGs to encourage and reward GP practices to further enhance the quality, safety and cost effectiveness of prescribing. They are one of many enablers to manage prescribing and their content can be shaped to deliver general improvement in prescribing principles or to focus on specific areas of concern within a locality. The DoH 2010 document ‘Strategies to achieve cost-effective prescribing’ discussed prescribing incentive schemes and identified the need to:
- inform GB members in advance and to publish details of the scheme’s arrangements on the CCG website
- ensure incentives do not conflict with or duplicate other funding rules (e.g. QOF) and must not reward for blanket prescribing of particular named medicines without consideration of the individual circumstances of the patients.

Key considerations
Prescribing incentive schemes are a means of incentivising and rewarding practice activity. With no national mechanism to reward this then further schemes may be justified in future years. They can also be effective enablers to accessing other funding sources such as a quality premium and easing pressure in future years.
The CCG recognises that a prescribing incentive scheme can help address variation in prescribing between practices as well as areas that the CCG as a whole should seek to improve. Its content should therefore identify areas where change is possible and will deliver benefits, not simply short term gains but that deliver stability to prescribing and financial and clinical improvement in the medium to long-term. There may be various means through which to improve performance and practices are advised to liaise with CCG Medicines Management for advice. With this in mind, the specified prescribing measures will be offered to all participating practices to address. Each topic will contribute to the maximum possible 100% and final payment will be awarded based on assessment against individual markers using ePACT data and audit reports relating to practice prescribing for the relative period. Practices will receive prescribing data for the measures as soon as analysis allows and around the end of June 2020, when final results are available.

The maximum incentive scheme payment for each practice for 2019/20 will be £0.30 per patient, calculated using each practice’s list size at a date to be determined by the CCG.

Prescribing indicators may have to be reviewed and adjusted should clinical evidence require a change to current prescribing practice. This may be in the form of NICE or other national prescribing guidance.

**Indicator definitions**

1. **a) Opioid analgesics:** reduce total spend (NIC) in BNF 4.7.2 in proportion to national NIC per 1000 cost based ASTRoPU per quarter. Measured using data from January to March 2020

   **Gateway (0%)** equal to the national cost/1000ASTRoPU for same period

   **Maximum (20%)** 20% below national cost/1000ASTRoPU for same period

   (Estimated CCG savings of £67K p.a. by a 10% reduction in costs in primary care prescribing in whole CCG)*

   Assessed using data from January to March 2020.

2. **b) Opioid analgesics:** reduce the number of patients prescribed an opioid analgesic (BNF 4.7.2) prescribed in primary care based on % number patients prescribed an opioid analgesic in an 8 week period taken directly from practice systems (as per CROP project; note excludes palliative care and drug misuse patients).

   Each practice’s target relates to their individual baseline position using data from February 19 (previous 8 weeks). Practices with highest prescribing of opiates are expected to make the greatest reduction to achieve the target.

   Practices with more than 5% patients prescribed an opioid analgesic at the baseline period: 15% reduction in number of patients prescribed an opioid analgesic.

   Practices with between 4- 5% patients prescribed an opioid analgesic at the baseline period: 10% reduction in number of patients prescribed an opioid analgesic.

   Practices with below 3% patients prescribed an opioid analgesic at the baseline period: Maintain the proportion of patients at the practice baseline level or below.

   Assessed using data from February to March 2020

   **Practices will be assessed against both measures above BUT a practice just needs to achieve one to get the payment.**

   This section is given a 25% weighting of the total incentive scheme
2. Audit of Direct oral anticoagulant (DOACS):

The audit is intended to improve patient safety and to identify safe systems are in place to reduce the occurrence of adverse events and ensure safe prescribing. This follows incidents highlighted by HDFT of patients been prescribed the incorrect dose of DOAC based on renal function. Current CrCl calculators embedded within GP IT systems do not give a reliable estimate of CrCl and can contribute to incorrect doses been prescribed putting patients at risk of adverse events. The aim of the audit is make sure that all existing patients prescribed a DOAC are on the correct dose and that systems are put in place for all new patients that MD+CALC Cockcroft-Gault equation is used in future to calculate renal function.

The 3 areas to target:

- Any new DOAC prescribing
- Annual medication review using the renal function check mandated in prescribing DOACs and
- Established DOAC users who need their drug doses checking.

Submit completed workbook to the medicines management team by 31st March 2020 or earlier.
This section is given a 25% weighting of the total incentive scheme

3. West Yorkshire and Harrogate Healthy Hearts Hypertension project

The aim of this project is to contribute to an overall reduction in CVD events in HaRD CCG. This will be achieved through increased detection of more patients with undiagnosed hypertension and identify and optimise the treatment of patients already diagnosed with hypertension

a) Audit the number of patients presently prescribed anti-hypertensives but not on the hypertension register to assess whether they should be added.
Baseline data provided is from April 2019.
Submit completed audit to the medicines management team by 31st March 2020 or earlier. Searches are available to allow practices to identify these patients (note this search excludes patients who are on other disease registers such as CHD, Diabetes, Heart Failure, PAD, Raynaud’s etc)
Aim is to increase cohort of patients on the hypertension register.
This section is given a 5% weighting of the total incentive scheme

b) Reduce the number of patients presently diagnosed and treated for hypertension and not achieving the target 140/90mmHg (note this excludes patients over the age of 80 years)  Baseline is using data from April 2019 which provides present number of patients on the practice hypertension register and not achieving the target 140/90mmHg
Gateway: Reduce the number of patients within this group by 50% (taken from Practice baseline + ((baseline-23) / 2))
Maximum Reduce the number of patients within this group to 23 per 1000 patients from baseline.
Note that 23 Searches are available which have been produced by West Yorkshire and Harrogate HCP. The overall aim is to move patients to be achieving the target of the best performing practice. This section is given a 25% weighting of the total incentive scheme.

4. Oral Nutritional supplement Prescribing

Reduce the spend (NIC) on oral nutritional supplements (sip feeds) prescribed in primary care in proportion to national total cost per 1000 cost based ASTRO-PU per quarter. Measured using prescribing data from January to March 2020.

Gateway: maintain or reduce the total cost/ASTRoPU value for the practice compared to the baseline of Q4 2018/19.

Maximum 10% reduction in total cost/ASTRoPU compared to Q4 2018/19

(Estimated CCG savings of £50K pa by a 10% reduction in primary care prescribing costs in whole CCG).

The use of sip feeds in HaRD CCG has risen by 13.9% over the past 12 months, compared to a more modest rise nationally of 3.7%

(Estimated CCG savings of £50K p.a. if by a 10% reduction in primary care prescribing costs in whole CCG)*

Medicines Management team would be available to support to identify patients that would warrant review.

This section is given a 25% weighting of the total incentive scheme. Practices achieving the gateway will achieve 15% of the payment and practices achieve an overall 10% reduction in total cost/ASTRoPU of ONS prescribing will receive an extra 10% payment.

Calculating achievement and incentive payment

Achievement and payment will be determined from the analysis of ePACT prescribing data of prescriptions submitted by NHS dispensing contractors for the time period specified for each measure. As this data is not immediately available, it will not be until 2020/21 that final data and payments can be calculated. Other sections require submission of audits to demonstrate achievement within that section.

The scheme is structured in a way to reward practices for partial achievement provided the initial gateway target has been satisfied. This should reward practices for delivering change to reach a more appropriate level, even if the full target has not been achieved. Achievement for each individual area will be paid separately, but practices are strongly encouraged to engage in all 4 areas of the incentive scheme. The medicines management team will arrange support visits to help practices in each of the areas.

Disputes

Solutions to any disputes should be agreed with the CCG Medicines Management Team and CCG Prescribing Lead before submission for approval to the CCG Finance, Performance and Commissioning Committee. Any disputes not resolved through this channel should be considered by the CCG’s Senior Management Team. This will be escalated further to the CCG Governing Body if early resolution cannot be achieved.

Chris Ranson          Dr Tim Rider
Medicines Management  CCG Prescribing Lead
Appendix 1

1) Opioid analgesics

Management of chronic pain in general practice is problematic. The World Health Organisation (WHO) ‘analgesic ladder’ was originally developed for cancer pain but its use has spread to chronic, non-cancer pain. There are growing concerns that: (1) patients are being moved up this ladder towards potent opioids inappropriately and without considering other drug and non-drug aspects of care; and (2) the potential social and medical harms of opioids have been significantly underestimated. Whilst opioids provide useful and effective analgesia in the short term for acute pain following trauma (including surgery) and cancer pain, the safety and efficacy of opioids for chronic non-cancer pain is uncertain. They can cause problems of tolerance, dependence and addiction.

The present Campaign to Reduce Opioid Prescribing (CROP) project run by West Yorkshire Research and development group is continuing to later this year which will provide bimonthly updates on the prescribing of opioids within your practice and guidance to support a reduction in the overall prescribing of opioids. The searches are designed to understand how many prescriptions of both strong and weak opioids are dispensed. With this information we are asking your practice to review your current opioid prescribing. Also within the reports will be references to the latest guidance, sample action plans, practice audit frameworks along with answers to questions relating to better pain management.

This year we will be using measures to demonstrate the impact of the project. But practices will only require to achieve one to get the payment. The first is a repeat from last year which uses spend (NIC) in BNF 4.7.2 in proportion to national NIC per 1000 cost based ASTRoPU per quarter in comparison with the national average and the second will be using the CROP data to reduce the number of patients prescribed an opioid analgesic (BNF 4.7.2) in primary care based on % number patients prescribed an opioid analgesic in an 8 week period taken directly from practice systems.

2) Audit of Direct oral anticoagulant (DOACS)

The dose of direct acting oral anticoagulants (DOACs) recommended depends on the indication, concomitant medication and a number of individual patient factors. The dose prescribed should be in line with licensed recommendations to reduce both the risk of thromboembolic events and bleeding complications. All of the DOACs are renally excreted so dose selection and modification may be necessary in patients with renal impairment. The choice of dose is guided by creatinine clearance (CrCl) using the Cockcroft and Gault equation. It is recommended that practices should use the MD+Calc website to access this equation to calculate renal function, this is an easily accessible web tool, familiar to GPs for the calculating things such as Wells Scores in risk of PE or DVT.

It is important to note that:

- Creatinine clearance is not the same as the estimated glomerular filtration rate (eGFR) which is reported by most pathology services and is used to stage levels of chronic kidney disease.
- In the landmark clinical trials for atrial fibrillation actual bodyweight was used to estimate creatinine clearance. There is debate, particularly in patients that are overweight, whether this is the best value to use when estimating creatinine clearance.
- There are a number of clinical tools available – web based and in primary care prescribing systems – that may be used for the CrCl calculation. They do not all use the same
methodology for weight in the equation and may give different answers for the CrCl estimate.

It should be noted that Estimated glomerular filtration rate (eGFR) should not be used, as data suggests this can lead to inappropriate dosing in up to 50% of patients. Current CrCl calculators embedded within GP IT systems do not give a reliable estimate of CrCl for the adjustment of DOAC doses and should not be used. Locally there has been evidence that patients admitted to HDFT have not been on the correct dose of the DOAC taking into account the patients’ renal function. In these cases it has been attributed to the renal function been calculated using the S1 renal function calculator which provided a different answer compared to calculating it using the Cockcroft and Gault equation in these cases resulted in under dosing for patients putting them at risk of a thromboembolic event.

Harrogate and Rural District are recommending to adopt the South London Calculating Creatinine Clearance for DOACs (see xxxxxx). This recommends using the MD+CALC Cockcroft-Gault equation can be accessed using the link: https://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation or it can be downloaded as an app to an apple device or android app.

Useful links
http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=2&SubSectionRef=02.08.02&SubSectionID=A100&drugmatch=3332#3332

South London Calculating Creatinine Clearance for DOACs guide:

Direct oral anticoagulant Audit tool

3) West Yorkshire and Harrogate Healthy Hearts Hypertension project

The nine Clinical Commissioning Groups within the West Yorkshire and Harrogate Health Care Partnership (HCP) have committed to tackling CVD and diabetes.

This project aims to contribute to an overall reduction in CVD events by 10% by 2021. This will be achieved through the detection of 18,000 more patients with undiagnosed hypertension and a further 39,000 people, who need to have their blood pressure controlled.

This will potentially prevent over 250 heart attacks and 400 strokes; having not only a massive positive impact on the lives of the people of West Yorkshire and Harrogate, but also a significant economic impact to the health and social care system.

The first phase is to improve management of hypertension which will consist of:

- Increasing recorded prevalence of hypertension
  - Identify patients already on anti-hypertensive medication but not on the hypertension register
  - Patients who have high blood pressure readings but who are not yet diagnosed

Treatment optimisation
- Identify and optimising the treatment of patients already diagnosed with hypertension (note that the data excludes patients over the age of 80 years which should not be treated to target of 140/90mmHG.

Note that searches are available (see link below) to allow practices to identify these patients.

West Yorkshire and Harrogate HCP have produced a lot of resources to support practices with this project:
4) **Oral Nutritional supplement Prescribing**

ONS are a medical intervention and should only be provided to patients who are classed as malnourished or at risk of malnutrition (using NICE definitions), where dietary intervention has not led to an improvement in nutritional status. In order to ensure the clinically and cost effective use of ONS, they should only be prescribed for specific Advisory Committee on Borderline Substances (ACBS) indications and should be prescribed appropriately in line with relevant guidelines. The conditions specified by the Advisory Committee on Borderline Substances (ACBS) for prescribing nutritional sip feeds include.

The ACBS indications for Oral Nutritional Supplements:

- Disease-related malnutrition
- Short Bowel Syndrome
- Intractable malabsorption
- Proven inflammatory bowel
- Following total gastrectomy
- Dysphagia
- Bowel fistulas
- Haemodialysis
- Pre-operative preparation of patients who are undernourished
- Continuous ambulatory peritoneal dialysis (CAPD)

Practices are encouraged to run a computer search to identify patients aged over 18 years who are currently receiving prescriptions for sip feeds (generically or by brand, all flavours) on repeat prescriptions. Initially, we suggest focussing on patients who are living at home, as anecdotal reports suggest these patients are less likely to have been reviewed recently, rather than those in a care home.

Below is a list of patients who may require review or amendment to their therapy:

- Patients whose conditions are not included in the ACBS criteria (see above)
- Patients who have not had a trial of “Food First”
- Patients prescribed low calorie supplements (≤1kcal/ml)

Note: ONS (Fresubin Original/Ensure), which contain less nutritionally and are not as cost effective as ≥1.5kcal/ml products. Products ≤1kcal/ml could be met with food fortification (e.g. whole milk with added skimmed milk powder is approximately 1kcal/ml).

- Patients with a documented MUST score of 1 or less
- Patients that have gained more than 5% in weight in 3-6 months or target weight/BMI has been achieved
- Any patient identified that you have any suspicion may not be using ONS appropriately (e.g. over-ordering)
- Any patients taking ONS long term (over 12 weeks) who have not been reviewed
- Any patient known to have a current problem of substance misuse
- Care home patients (care homes should be able to provide adequate nutrition and it may be difficult for these patients to attend appointments)
- Any patients with no documented weight, MUST score or indication for ONS
• Any patients who are discharged from hospital on ONS with no on-going dietetic review process in place will not automatically require ONS on prescription once home.
• Any patient consistently unable to manage 2 servings of ONS per day, as they are unlikely to derive any significant benefit to well-being or nutritional status. To be clinically effective it is recommended that ONS be prescribed twice daily.
• Any patient on ‘starter packs’ as more costly – these should only be prescribed as an initial trial.
• Any patient on ‘juice style supplements’ unless they have lactose intolerance or dislike milky taste

Patients who may require special consideration
• Palliative care patients. Emphasis should always be on the enjoyment of nourishing food and drinks and maximising quality of life.
• Liver disease
• Dysphagia
• Cystic Fibrosis
• Patients who have previously had bariatric surgery
• Enterally (tube) fed patients
• Patients who have had a recent review from a dietician
• Patients on dialysis
• Patients Chronic Kidney Disease Stage 3 (particularly Stage 3b), Stage 4 and 5

Prescribing tips
• Provide open prescriptions were possible to allow the patient to choose their favourite flavours in conjunction with their local pharmacy
• Prescribe between 2-3 cartons of sip feed per day between or after meals and not before meals or as a meal replacement.
• Review progress initially after 2-4 weeks then regularly review at least every 3 months
• If there is no change in weight after 3 months ONS should be reduced and stopped.
• Advise patients to chill sip feeds
• Suggest neutral flavour sip feeds for use in cooking or in place of milk
• Check compliance with ONS and stock levels at home/care home.
• If the patient no longer meets ACBS criteria, or goals are met, but still wishes to take ONS, suggest over the counter products e.g. Build-Up®, Complan® or Nurishment®
• Patients with diabetes should not routinely be prescribed fruit juice based ONS i.e. Fresubin® Jucy, Resource® Fruit, Fortijuce®, Ensure® Plus Juice. This is because these products have a higher glycaemic index, and blood glucose levels will need monitoring, with possible changes required to medication.

When to stop sip feeds
- Patient is not taking them (another type or flavour of supplement may be appropriate in certain cases)
- When BMI increases to normal/“MUST” score is low risk
- Patient’s appetite returns to normal and they are achieving a balanced, nutritionally adequate diet.
- Their medical condition has resolved e.g. pressure sore healed and patient is eating well

References
Useful Resources
The online MUST calculator is available via [http://www.bapen.org.uk/screening-for-malnutrition/must-calculator](http://www.bapen.org.uk/screening-for-malnutrition/must-calculator).


Fabulous Fortified Feasts - containing recipe ideas for a fortified diet via [https://www.prescqipp.info/headline-areas/nutrition#fabulous-fortified-feasts](https://www.prescqipp.info/headline-areas/nutrition#fabulous-fortified-feasts)