SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	TBC
Service	Quality Prescribing Scheme
Commissioner Lead	David Birch
Provider Lead	Practice specific
Period	1st April 2017
Date of Review	31st March 2018

1. Population Needs

1.1 National/local context and evidence base

Participation in this Local Prescribing Incentives Services requires the practice to have a commitment to prescribing within the allocated prescribing budget, including prescribing in line with the Joint Formulary.
The practice should have a robust approach to antibiotic stewardship and prudent prescribing of antibiotics.
The practice should engage with prescribing support activities (e.g. evidence of timely participation in agreed cost-efficiency programmes, minutes from practice meetings demonstrating engagement with the Primary Care Medicines Team and completion of agreed actions).

In addition the practice can demonstrate that:

- ScriptSwitch is utilised by all prescribers
- Eclipse Live must be activated at the practice for use by the Primary Care Medicines Team

PART 1: Antibiotic prescribing (£400 per 1000 patients)
Aim
Review and, if appropriate, revise current prescribing practice and use implementation techniques to ensure prescribing is in line with Public Health England guidance this includes control of the total volume of antibiotic prescribing. Implementing the above will also help Wolverhampton CCG achieve its Quality Premium. Practices will need to access and use the guidance available at https://www.prescqipp.info/projects/antimicrobial-stewardship#target-antibiotics and where necessary have ensured the practice has undertaken training in antibiotic stewardship.

Background information
Antibiotic resistance continues to be a public health issue. The consequences of antimicrobial resistance (AMR) include increasing treatment failure for the most commonplace infections for example, urinary tract infections and decreasing the treatment options available where antibiotics are vital. Antibiotic prescribing and antibiotic resistance are inextricably linked.

Overuse and incorrect use of antibiotics are major drivers of resistance.

To help prevent the development of resistance it is important to only prescribe antibiotics when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats. This year NHS England has introduced a mandatory quality premium to improving antibiotic prescribing in primary and secondary care. The aim of the quality premium is to reduce over use and inappropriate use of antibiotics in order to reduce the spread of antimicrobial resistance.

Wolverhampton CCG will be measured on the full 2017-18 financial year prescribing data set published by the NHS BSA in June 2018 against prescribing rates based on the financial year 2013-14 NHS BSA prescription services data set. The Quality premium will only be achieved if the CCG can demonstrate a performance equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU. In addition the number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care to be equal to or lower than 10%.

Public Health England (PHE) guidance recommends that simple generic antibiotics should be used if possible when antibiotics are necessary. The PHE website also has more information on antibiotic resistance, and resources to help reduce inappropriate antibiotic prescribing.
The local formulary primary care guidance is available at:
http://www.wolverhamptonformulary.nhs.uk/formulary/BNF/Section%205%20Infections/bnf5.asp

Useful Resources:
NPC's e-learning resource on antibiotics:
http://www.npc.nhs.uk/qipp/qipp_elearning/antibiotics_elearning.php

RCGP TARGET 'Antibiotic Resistance in Primary Care' e-learning module
http://www.rcgp.org.uk/clinical-and-research/target-antibiotics-toolkit.aspx

PART 2a: Antibiotic prescribing for UTI in primary care (£150 per 1,000 patients)

Aim
To reduce or maintain prescribing below a specific ratio of trimethoprim to nitrofurantoin prescribing for UTI in primary care.

The required performance in 2017/18 - the ratio of trimethoprim to nitrofurantoin prescribing to be below 1.580 (based on CCG baseline data (June15-May16) for 2017/18.

PART 2b: Antibiotic prescribing for UTI in primary care (£150 per 1,000 patients)

Aim
To reduce or maintain the number of items prescribed for trimethoprim in primary care.

The required performance in 2017/18 - a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2017/18

PART 3: Hypnotics optimisation (£125 per 1000 patients)
Aim
The risks associated with hypnotics, such as falls, cognitive impairment, dependence and withdrawal symptoms, are well recognised. Hypnotics should be used only if insomnia is severe, using the lowest dose that controls symptoms for short periods of time. Review and, if appropriate, revise prescribing of hypnotics to ensure that it is in line with national guidance.

Background information
Risks associated with the long-term use of hypnotic drugs include falls, accidents (including motor accidents, cognitive impairment, dependence, withdrawal symptoms and increased risk

of death).

The NICE technology appraisal guidance on zaleplon, zolpidem and zopiclone recommends that when, after due consideration of the use of non-pharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications. The NICE technology appraisal guidance states that there is no compelling evidence of a clinically useful difference between the 'Z drugs' and shorter acting benzodiazepine hypnotics from the point of view of their effectiveness, adverse effects, or potential for dependence or abuse. There is no evidence to suggest that if people do not respond to one of these hypnotic drugs, they are likely to respond to another.

PART 4: NSAIDs (£100 per 1000 patients)

Aim
To encourage the review of the appropriateness of non-steroidal anti-inflammatory drug (NSAID) on a routine basis, especially in people who are at higher risk of gastrointestinal, renal and cardiovascular morbidity and mortality (for example, older people).
If an NSAID is needed, ibuprofen (1200 mg a day or less) or naproxen (1000 mg a day or less) should be used.
Prescribing should be the lowest effective dose for the shortest duration of treatment necessary to control symptoms. Co-prescribe a proton pump inhibitor with NSAIDs in line with NICE guidance.

Background information
There are long-standing and well-recognised gastrointestinal and renal safety concerns with all NSAIDs. There is also substantial evidence confirming an increased risk of cardiovascular events with many NSAIDs, including COX-2 inhibitors and some traditional NSAIDs such as diclofenac and high-dose ibuprofen.

PART 5: Low cost Blood Glucose Testing Strips(BGTS) (£150 per 1000 patients)

Aim
The cost of prescribing blood glucose testing strips is growing rapidly and there are significant savings to be made by rationalising prescribing.
Self-monitoring of blood glucose in type 2 diabetes is only beneficial for a selective group of patients and this practice should be restricted in line with NICE guidelines, see link to guidance below,
https://www.nice.org.uk/guidance/ng28/chapter/1-Recommendations#self-monitoring-of-blood-glucose

Prescribing of BGTS should be based on a patient's individual needs and patients should receive a product from the preferred list of blood glucose testing strips and meters to be used locally.

BGTS with an acquisition price under £10 are deemed to be cost-effective and a target has been set to reflect this.

Background information
Self-monitoring of blood glucose (SMBG) is essential for people with diabetes on insulin therapy and can be beneficial for some people on other hypoglycaemic agents. Where SMBG is not serving a specific purpose in the management of the condition however, it is a waste of resources and can cause unnecessary pain to the patient. NICE recommends that SMBG should be used only if it is going to be an integral part of the patient's self-management education, and the continued benefit of self-monitoring should be assessed in a structured way each year.

Part 6: Lower cost branded buprenorphine patches (£125 per 1000 patients)

Aim Substantial savings could be achieved if buprenorphine 5 mcg, 10 mcg and 20 mcg transdermal patches are prescribed as Butec® or Sevodyne® 5 mcg, 10 mcg and 20 mcg patches respectively. These brands are currently 55% less expensive than generic buprenorphine patches and Butrans® patches (based on MIMS/Drug Tariff Jan-17 prices).

Background information
If strong opioids are required, oral morphine should be the first choice for most patients and is a cost effective choice compared with other stronger opioids, such as fentanyl, buprenorphine and oxycodone, which are considerably more expensive.

Part 7 : Diabetic pen needles (£125 per 1000 patients)

Aim

Prescribing data show that 7% of the total cost of prescribing for diabetes is spent on hypodermic devices. Significant savings can be made by reviewing and switching patients to a more cost-effective pen needle within the range of prescribable needles for pre-filled and reusable pen Injectors. Pen needles with an acquisition price under £6 per 100 needles are deemed to be cost-effective and a target has been set to reflect this. The target of 60% has been set a level to support the fact that some patients will require a safer sharps pen needle therefore the needs of patients, carers and health professionals who administer the medication should be considered before any change

Part 8: Lower cost branded tiotropium inhalers (£200 per 1000 patients)

Aim

Substantial savings could be achieved if a breath actuated tiotropium inhaler is prescribed as branded Braltus® instead of prescribing generically or as branded Spiriva Handihaler®. In addition Spiriva Respimat which is licensed for asthma and COPD is a cost effective choice. There have been several developments with tiotropium inhalers recently. Following the expiry of tiotropium's UK patent, the first lower cost 'equivalent' to Spiriva Handihaler® was launched by Teva under the brand name Braltus®. Also, the price of Spiriva Respimat® (tiotropium aqueous solution for inhalation) dropped substantially in the last year.

It is important to note that Braltus® has been named according to the dose of tiotropium that is 'delivered' (i.e. the dose that leaves the mouthpiece), whereas the reference product Spiriva Handihaler® (tiotropium 18 microgram powder for inhalation capsules) is named according to the 'pre-metered' dose of tiotropium. The pre-metered dose for Braltus® is 13 micrograms. However, both products provide the same 'delivered' 10 microgram dose of tiotropium.

Dosing regimens are the same for both products (inhalation of the contents of one capsule, once daily), using the products' respective delivery devices, which, in the case of Braltus®, is the Zonda® device.

The therapeutic indications for Braltus and Spiriva Handihaler are identical, with both licensed as maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). (Note - tiotropium is also indicated as an add-on maintenance treatment in asthma, however, this applies only to the Spiriva Respimat® aerosol inhaler – neither Spiriva Handihaler® or Braltus® are licensed for use in asthma.)

Part 9: Brand prescribing of Inhaled corticosteroid, long acting muscarinic antagonists and combinations with long-acting beta agonists inhalers (£125 per 1000 patients)

Aim

Over the past few years there have been a vast increase in the number of inhalers available within the UK market. As a result it is recommended that all inhalers are prescribed by brand name to ensure the patient receives the same device. This is especially important for steroid

based inhalers which are not interchangeable.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-healt or following injury**	√
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

- To reduce the overall rate of antibiotic prescribing in line with national guidance. This will slow the development of antibiotic resistance.
- To reduce hypnotic prescribing in line with national trends to minimise risk and provide better outcomes for patients
- To reduce the cost of blood glucose monitoring whilst maintaining benefit in those patients who need to test
- To reduce NSAID prescribing in line with national trends to minimise risk and provide better outcomes for patients

3. Scope

3.1 Aims and objectives of service

- Good antibiotic prescribing is a well-established indicator of quality prescribing. To maintain the control of antibiotic prescribing in line with national guidance. This will slow the development of antibiotic resistance and ensure clinical appropriateness and benefits to the patient
- Achieve the Quality Premium requirements for the CCG.
- Support for QIPP

3.2 Service description/care pathway

Prescribing incentive scheme

Scheme Details for Part 1 - Antibiotic prescribing

Practices are required to reduce or maintain antibacterial prescribing as per national guidance. The items per STAR-PU must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU and the number of co-amoxiclav, cephalopsorins and quinolones as a proportion of the total number of selected antibiotics must be equal to or lower than 10% (April 2017 to March 2018).

Monitoring and Payment

PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available. Payment is not conditional on Wolverhampton CCG achieving the Quality Premium.

Scheme details for Part 2a - antibiotic prescribing for UTI in primary care.

Practices are required to reduce or maintain antibacterial prescribing below a specific ratio of trimethoprim to nitrofurantoin prescribing for UTI in primary care.
The ratio of trimethoprim to nitrofurantoin prescribing must be below 1.580 (based on CCG baseline data (June15-May16) for 2017/18.

Scheme details for Part 2b - antibiotic prescribing for UTI in primary care.
Practices are required to reduce antibacterial prescribing trimethoprim items prescribed to patients aged 70 years by 10% or greater on baseline data (June15-May16) for 2017/18.

The specific number of items will be based on the practices current prescribing rate (June 2015 to May 2016), thus each practice will be set a specific target which will cover their prescribing data for the period April 2017 to March 2018 as indicated in the scheme details.

Scheme Details for Part 3 - Hypnotics
The prescribing of benzodiazepine hypnotic items in January 2018 to March 2018 will be analysed via epact searches to determine each practices position. Practices at or below 0.24 ADQ/STARPU (national average) will need to remain below that target. Practices with prescribing rates above that will need to reduce to that level or by 10%.
For this scheme where practice believe they have been unable to achieving the target as a result of recommendations from mental health consultants that are beyond their control they should provide audit data to allow for an adjustment to be made to their data.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 4 - NSAIDs
The prescribing of NSAID items in January 2018 to March 2018 will be analysed via epact searches to determine each practices position. Practices at or below (1.280) ADQ/STARPU will need to remain below that target. Practices with prescribing rates above that will need to reduce to that level or by 10%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 5 - Low cost glucose testing strips
The practice prescribing of low cost BGTS (less than £10 per pack) as a % of all strips will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 60%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 6 - Branded buprenorphine patches & morphine as a % of all opioid prescribing.

The practice prescribing of low cost once weekly buprenorphine 5, 10 & 20mcgs patches as a % of all buprenorphine 5, 10 & 20mcgs patches will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 75%.

The percentage of oral morphine prescribing as a percentage of strong opioid prescribing must

be above 40%. Both elements must be achieved to qualify for payment.
For this scheme where practice believe they have been unable to achieving the target as a result of recommendations from secondary care / other care sectors e.g. hospice that are beyond their control they should provide audit data to allow for an adjustment to be made to their data.

Monitoring and Payment

PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 7 – Diabetic Pen needles

The practice prescribing of low cost hypodermic needles (less than £6 per pack) as a % of all hypodermic needles will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 60%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 8 - Lower cost branded tiotropium inhalers

The practice prescribing of low cost branded tiotropium (Braltus® & Spiriva Respimat®) as a % of all tiotropium prescribing will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 50%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 9: Brand prescribing of Inhaled corticosteroid, long acting muscarinic antagonists and combinations with long-acting beta agonists inhalers (£125 per 1000 patients)

The practice prescribing of branded inhalers as a % of all inhaler prescribing will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 95%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

3.3 Population covered
For GP practices in Wolverhampton

3.4 Any acceptance and exclusion criteria and thresholds
None

3.5 Interdependence with other services/providers

None

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)
NICE guidance will be implemented.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)
None

4.3 Applicable local standards
None

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)
None

5.2 Applicable CQUIN goals (See Schedule 4D)

None

6. Location of Provider Premises

The Provider's Premises are located at:
As per the contract

7. Individual Service User Placement

None