MEDICINES OPTIMISATION PRESCRIBING SCHEME 2023-24

Gateway Entry - Engagement & Development	
Practices must meet with the ICB MMT to promote engagement, staff development and to agree to work on the Scheme. Practice must meet on at least 2 occasions and agree to engage with MMT prescribing initiatives throughout the financial year.	
Part A – Quality and Safety (65% Value)	
Eclipse RADAR Improved Clinical Safety & reduced admissions	**Rationale:** Eclipse Radar is a medicines optimisation dashboard focused on improving patient safety. It identifies patients at risk of emergency hospital admissions and aims to combat the thousands of deaths each year caused by medication-related incidents – more than half of which are preventable. Eclipse latest software, VISTA, can be used at individual practice level and as population management tool to identify opportunities, implement solutions and validate improvements for patient populations. The system has been designed to reduce workload through increased efficiencies, increase revenue and improve validation of safe practice. **Resources:** Eclipse Radar risk stratification software improves safety by identifying those patients most likely to have an emergency admission from a reversible cause. **Target:** Practices must also commit to regular data extractions and practice must: • Review 100% of patients with a RADAR alert highlighted under the 'CCG Alerts' icon on a weekly basis. • Action alerts within 10 days, otherwise they will not be counted as reviewed. **Reporting:** No practice reporting required. MMT report will validate practice achievement monthly.
Eclipse Pathways Reduce polypharmacy & adverse effects	**Rationale:** Anticholinergic medicines should be prescribed with caution as elderly patients are more likely to experience side effects such as constipation, urinary retention, dry mouth/ eyes, sedation, delirium, falls and reduced cognition (which may be wrongly diagnosed as dementia). Research also suggests a link to increased mortality with the number and potency of anticholinergic agents prescribed. (Ref NHS Scotland Polypharmacy Guidance http://www.sign.ac.uk/pdf/polypharmacy_guidance.pdf). • Each definitive anticholinergic may increase the risk of cognitive decline by 46% over 6 years. • For each one-point increase in the ACB total score, a decline in Mini Mental State Exam (MMSE) score of 0.33 points over 2 years has been suggested. • Each one-point increase in ACB total score has been correlated with a 26% increase in the risk of death. **Resources:** Eclipse Pathways Cohort to identify Patients with ACB Score >= 6 **Target:** All practices to reduce the percentage of patients >= 65yrs with an anticholinergic burden score of 6 or greater in Jan- Mar 24 compared to their baseline Jan – Mar 23 AND for those practices above the England Average to reduce to below or at England average in Jan – Mar 24 **Reporting:** MMT report will validate practice achievement monthly. Practices should retain a record of the
TARGET Antibiotics NHSE quality Indicator	**Rationale:** The UK 5 - year antimicrobial strategy states that there are few public health issues of greater importance than antimicrobial resistance in terms of impact on society. The strategy promotes optimal use of antimicrobials to ensure safe and effective patient care. Practice should: • Only prescribe antibiotic courses when they are necessary and not for self-limiting mild conditions. • Use the shortest effective course. NICE and PHE antimicrobial prescribing guidelines include recommendations course length of antibiotics. Shorter courses of antibiotics have been associated with less adverse drug events and less resistance. **Resources:** RCGP TARGET Antibiotic Toolkit UTI and RTI audits, patient leaflets. Also consider use of EMIS templates, delayed prescriptions, review of the long-term antibiotics and telephone ordering. **Target:** Reduction in Items per 1000 STAR PU in Apr 23 – Mar 24 to below or at national average or achieve 5% relative reduction compared to practice baseline Apr 22 – Mar 23. **Reporting:** No practice reporting required. The medicines management team will use NHS BSA prescription data to monitor performance against this target.
Reducing overuse of reliever inhalers (SABA) in Asthma	**Rationale:** Patients prescribed three or more SABA inhalers per year are more likely to have an asthma attack and even die prematurely. As SABA inhalers have no inherent anti-inflammatory pharmacological properties, they do not control the underlying airway inflammation that causes asthma. In fact, overuse of SABA inhalers can mask the progression of the disease and increase hyper-responsiveness in the airways, leading to greater sensitivity to triggers. **Resources:** A resource pack and eLearning will be provided to practices to help with this area. Referral to Community Pharmacy/PCN teams for NMS/Inhaler technique/SMR. **Target:** Reduction in the prescribing of reliever inhalers (SABA) per Bronchodilators COST based STAR PU by 10% or below the England average (Jan-Mar 23 vs Jan-Mar 24). **Reporting:** The medicines management team will use NHS BSA prescription data to monitor performance against this target. The numbers of patient with asthma on a SABA with 7+ issues in 12m will be monitored using an EMIS data extract.

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Prescribing of Opioids

Rationale: The Faculty of Pain Medicine (Royal College of Anaesthetists) Opioids Aware project seeks to improve prescribing of opioid analgesia. The opioid dose for which harms outweigh benefits is 120mg oral morphine or equivalent/24hours. Above this dose, the risk of harm and mortality increases substantially but there is no increased benefit. Patients often confuse sedation/euphoria caused by opioids with pain relief. Long term use leads to tolerance to the analgesic effects and can increase pain sensitivity (e.g., hyperalgesia and allodynia). If a patient has pain that remains severe despite opioid treatment it means opioids are not working and they should be tapering or stopping after careful planning, even if no other treatment is available.

Resources: A resource pack and eLearning will be provided to practices to help with this area.

Target: Practices must reduce their Total Opioid prescribing (as oral morphine equivalence) per 1,000 STAR PUs by 5% or below England average (Jan-Mar 23 vs Jan-Mar 24). This measure describes ALL opioid prescribing including low-dose opioids in drugs such as Oramorph and co-codamol but excludes prescribing for addiction and injectables.

Reporting: No practice reporting required. The medicines management team will use NHS BSA prescription data to monitor performance against this target.

Gabapentin and pregabalin reviews

Rationale: Public Health England has provided information on the risks of gabapentin and pregabalin. Both cause adverse effects on the central nervous system, which are additive when used with other centrally acting drugs e.g., opioids. Professionals should be aware that the drugs can lead to dependence and may be misused or diverted.

Resources: A resource pack and eLearning will be provided to practices to help with this area.

Target: Practices must reduce their ADQ per 1,000 STAR PUs of pregabalin and gabapentin by 5% or below England Average (Jan-Mar 2023 vs Jan-Mar 2024)

Reporting: No practice reporting required. The medicines management team will use NHS BSA prescription data to monitor performance against this target.

Part B -Managing Prescribing Spend (35% Value)

Managing Prescribing Spend & Supporting Self-Care

Rationale: Managing medicines cost-effectively is a key part of effective prescribing. This element of the scheme promotes the use of lower cost medicines where there is good evidence to support their use, while promoting good quality prescribing for all disease areas.

The main aim is to encourage practices to manage their prescribing budget and achieve comparable cost- based ASTRO PUs, thus reducing variation across practices.

Resources & Plans: Practices to identify a Practice Medicines Coordinator (non-clinical staff member that manage or supports the repeat prescribing process). The Practice Medicines Coordinator must complete or have completed (in the last 3 years) the PrescQIPP training (attached), attend two workshops and support with Medicines Optimisation quality & safety objectives and savings plan delivery (10% of the scheme).

AND

Practices should develop and agree individual plans detailing areas of cost efficiency work with their medicines management team. The areas of cost efficiency may include:

- Unlicensed specials, Black & Red Traffic light items
- Quantity, dose and formulation optimisations
- Emollients to formulary range
- Buprenorphine & fentanyl patches, oxycodone & morphine tabs/caps to formulary brands of choice
- Quetiapine XL to formulary brands of choice
- Keppra brand to generic levetiracetam (https://www.epilepsy.org.uk/info/treatment/anti-epileptic-drug-treatment/switching-between-different-versions-of-epilepsy-medicine)

AND

Practices MUST have activated and be actively engaging with OptimiseRx. Practices should aim for an acceptance rate of 30% or above OptimiseRx national average.

Target: Practices must work towards a reduction in cost/ASTRO-PU at or below England average (25% of the scheme).

- Practices below England average (GREEN) on Mar 24 will **ONLY** receive full payment if they maintain green status and if the savings action plans have been delivered and OptimiseRx target achieved.
- Payment for practices above the England average as of Mar 24 will be paid based on their reduction compared to England growth as per table below:

Practice cost growth reduction greater than England Ave	0 - 0.99%	1 - 1.99%	2 - 2.99%	>=3%
Payment	6.25%	12.5%	18.75%	25.0%

Reporting: Practices should continually maintain their plans with the management team. The medicines management team will use NHS BSA prescription data and OptimiseRx reports to monitor performance against this target.