PostScRipt – PrimaRy Care

March 2008

NHSGGC SIP FEED AUDIT: The sip feed audit is a GP practice based audit that is designed to identify patients who have been on sip feeds (prescribable nutritional supplements eg fortisip®) for 3 months or more.

Why are we asking GPs to do this audit?
Sip feed prescribing in Greater Glasgow increased by almost 20% in 06/07, from £2.66 million in 05/06 to £3.16 million in 06/07. Reductions in sip feed prescribing expenditure have been achieved by another health board using a similar audit process. From November 2007 to February 2008, 27 GP practices have completed the audit and have referred 122 patients for nutritional assessment to the project dietitians.

The sip feed audit funding has been extended and will now run until the end of March 2009. For further information please contact Vicki Welch 0141 201 5928 or email: vicki.welch@nhs.net

CLOPIDOGREL: Since the 3rd March 2008 there has been a change to the hospital supply arrangements of clopidogrel in patients who have had a drug eluting stent (DES) inserted. Previously patients were given six months supply on top of their aspirin and GPs had to prescribe another 6 months to ensure patients received the recommended one year course. **Now all DES patients will be discharged with the standard prescription length for the hospital concerned (up to one month).** GPs are now expected to continue prescribing for the remainder of the course (one year, unless otherwise specified by the cardiologist).

Hospital supplies of clopidogrel as part of fixed course dual antiplatelet therapy for other indications such as acute coronary syndrome are unaffected. These supply arrangements are being applied across all hospitals in NHSGGC including the Golden Jubilee.

Supply details and recommended duration of dual therapy should be detailed in discharge prescriptions and letters. Patients are also being issued with a leaflet explaining the duration of their course and are asked to give a copy to their GP. The revised NHSGGC antiplatelet guidelines are expected in the second quarter of 2008.

KEEP WELL – SMOKEFREE ENHANCED SERVICE: There are two community pharmacy projects involved in the delivery of the Keep Well service to the North and East of Glasgow. These key services are the Long Term Medicine Service and the Smokefree (previously Starting Fresh) enhanced service. The aim of the Smokefree enhanced smoking cessation service is to support smokers to successfully give up smoking who have relapsed during previous NHS quit attempts.

- Clients are identified from a database as having matched inclusion criteria and will be invited to attend their local accredited pharmacy to receive weekly intensive support. This is based on adopting motivational interviewing techniques as well as intensive behavioural support
- An additional advantage of the enhanced service is the option to supply combination NRT. If the client requires top up doses of NRT in addition to patches this can be prescribed under a patient group directive (PGD) at any time during the 12 week service.
- To provide this enhanced service pharmacists and support staff must attend the formal smokefree service training plus additional training for the enhanced service.
- The service also allows signposting and referral of clients to other Keep Well services that may impact on health such as weight management, alcohol counselling or benefit advice.
- If the client is not suitable for inclusion into the enhanced service the smoking cessation adviser can refer onto more appropriate services such as the smokefree pharmacy service or the smokefree group services

See Postscript PrimaryCare October 2007 for more information on Keep Well.

PRESCRIBING INCENTIVE SCHEME
NHSGGC 2008/2009

INDICATORS FOR 08/09: The Rational Prescribing Incentive Scheme for 08/09 has been agreed by the Prescribing Management Group (Primary Care) formerly the Medicines Resource Management Group (MRMG). The scheme will consist of two CH(C)P fixed prescribing indicators and one practice based prescribing indicator. As in previous years the indicators will be selected based on the potential to generate the most savings for the CH(C)P and the GP practice. A payment of £200 for every 1000 patients will be paid for each target achieved with a bonus of £100 per 1000 patients where all three indicator targets have been met. The 08/09 incentive scheme will be launched two months earlier this year with the ***final measurement*** determined using ***Oct-Dec 2008 data***. The three prescribing indicators for the scheme are selected from the following:

Indicator	Target
Lansoprazole & omeprazole (excluding FasTabs & MUPs) as a % of all single agent oral PPIs Rationale: *Lansoprazole and omeprazole are the PPIs of choice in the Preferred List*	**≥90%**
AIIRA as a % of all ACEI and AIIRAs Rationale: *National and local guidelines suggest that ACEI should be first line with AIIRAs reserved for patients who cannot tolerate ACEIs. This is an indicator of prescribing efficiency from Audit Scotland and the National Audit Office report.*	**≤22%** (or absolute decrease of 5%)
Co-codamol 8/500, co-codamol 30/500 and paracetamol tablets, capsules or caplets as a % of all solid dose co-codamol and paracetamol Rationale: *Effervescent formulations contain significant amounts of sodium which can affect control of hypertension and are premium priced. The Preferred List restricts use of effervescent formulations to those with swallowing difficulties. Co-codamol 8/500 and 30/500 are the only strengths in the Preferred list,all other strengths are non Formulary.*	**≥90%**
Clopidogrel as a % of all antiplatelet drugs Rationale: *GP Audits suggest that clopidogrel is being used outwith the antiplatelet guidelines. This has a significant cost implication. Inappropriate combination use with aspirin raises potential safety issues.*	**≤10%** (or an absolute decrease of 5%)
Standard diclofenac sodium, ibuprofen & naproxen as a % all NSAIDS including COX2 Rationale: *Diclofenac & ibuprofen are drugs of choice in the Preferred List. The MHRA noted naproxen may be less likely than other NSAIDs to have adverse CV events*	**≥65%**
Alendronate as a % of all oral bisphosphonates prescribed for osteoporosis (excluding daily doses) Rationale: *This is the oral bisphosphonate of choice for osteoporosis in the Formulary*	**≥85%** (or an absolute increase of 10%)
Preferred List antidepressants as a % of all antidepressants items (excluding amitriptyline) & **Fluoxetine & citalopram as a % all of all SSRIs, duloxetine (30mg & 60mg), mirtazapine, reboxetine and venlafaxine items** Rationale: *Fluoxetine and citalopram are both drugs of choice in the Preferred List. Where fluoxetine or citalopram are ineffective or not tolerated then mirtazapine or lofepramine may be prescribed as an alternative. Both drugs are listed as alternative antidepressant treatments in the Preferred List and in the antidepressant guidelines*	**≥60%** (or an absolute increase of 5%) & **≥65%** (or 5% absolute increase)
% of formulary choices of all prescribing in BNF 2.12 **&** **Simvastatin as a % of all statins** Rationale: *Simvastatin is the statin of choice in the Preferred List*	**≥96%** (or 5% absolute increase) & **≥65%** (or 10% absolute increase)
loratadine & cetirizine as a % of all non-sedating antihistamines Rationale: *These are the two non-sedating antihistamines listed in the Preferred List*	**≥85%**
Omeprazole capsules as a % of all omeprazole capsules and tablets Rationale: *Capsules are a more cost effective formulation*	**≥95%**
Ramipril capsules as a % of all ramipril capsules and tablets Rationale: *Capsules are a more cost effective formulation*	**≥95%**
Generic tamsulosin MR capsules as a % of all tamsulosin MR Rationale: *Caps are available generically at a lower cost than branded tablet formulation*	**≥95%**

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