NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

Prescribing Incentive Scheme 2017-18

(Full version) v1.1

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Document Control Sheet

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Revision History

Revision Date	Summary of changes	Author(s)	Version Number

Approvals

This document requires the following approvals either individual(s), group(s) or board.

Name	Title	Date of Issue	Version Number
	Waveney Prescribing Leads	15/03/17	1.0
	Great Yarmouth Prescribing Leads	11/03/17	1.0
	Clinical Executive Committee		1.0
	Senior Management Team		1.0
	Governing Body	30/03/17	1.0

Summary of indicators for 2017-18 incentive scheme

Entry Criteria			
Service Restrictions			
• **Gluten Free**	No gluten free prescribing, limited PKU prescribing		
• **Co-proxamol**	No scripts issued		
• **Brand to generic**	List produced for Q4 prescribing – all patients written to – 50% reduction in spend.		
Medicines Management	Nominate a practice medicines lead		
Patient Participation	Engage with PPG on self - care		
Monthly Fee for work completed			
	Send in a report monthly indicating work done, this can include any in-year initiatives.	0.5	**6**
Indicators			
1.	90% of Pregabalin as low cost	1.5	**13.5**
2.	70% of tiotropium as low cost	1	**9**
3.	95% of low cost quetiapine	1	**9**
4.	90% of AD drugs prescribed cost-effectively	0.5	**4.5**
5.	Self-care reduction by 10% or below target	1.5	**13.5**
6.	60% of lower cost emollients	0.5	**4.5**
7.	Below antibiotic volume threshold or a percentage reduction	0.5	**4.5**
8.	70%of sip feed spend – reduce rx and use more cost-effective	1.5	**13.5**
9.	80% of low cost BGTS	1	**9**
10.	Weekly log-in to Eclipse to review 100% of higher risk (red) alerts	0.75	**9**
Audits			
1. Self-audit against repeat prescribing protocol	Implement Appendix A from repeat prescribing document, send in audit results and action plan. Review audit 6m later.	1	**1**
2. Antibiotics if above national targets	Review discretionary use of URTI, formulate action plan and repeat audit 6m later.	1	**1**
3. Other agreed audit 1	Agreed at practice visit	1	**1**
4. Other agreed audit 2	Agreed at practice visit	1	**1**
Bonus Payments			
1. ScriptSwitch feedback	At least 2 items of feedback per month	1	**1**
2. Medicines lead nominated and attends 80% of meetings	After nominating the practice medicine lead they will receive some training and support from the CCG technicians to improve rx issuing and support the prescribing lead.	2	**2**
3. Building and developing relationships with Community Pharmacies	Nominate a member of the practice team as the eRD lead. Submit evidence of an initial meeting with local pharmacies to enable collaborative working with local community pharmacies who dispense for patients registered with your practice.	2	**2**

Performance against indicative budget

- Practices that perform against budget will receive full payment from the scheme.
- Practices which are overspent will be given a full payment if they reduce their percentage overspend by 1/3. For example, a practice which is 18% overspent would need to reduce to 12%, and a practice which is 6% overspent would need to reduce to 4%.
- Outlying practices will be given extra support to achieve savings. This will include input to improve practice systems, and must also include engagement from prescribers to change behaviour. This will include the establishment of a system of prescribing leadership within the practice if it does not already exist, and regular attendance at meetings with the CCG to improve safety, effectiveness and cost-awareness. These changes will need to be made quickly so that end of year variance from budget is minimised.
- Practices that are significantly overspent and do not improve their percentage overspend will have their final payment reduced.

    - 1-5% over budget = 15% reduction in payment
    - 5-10% over budget = 30% reduction in payment
    - >10% over budget = 50% reduction in payment

General comments

The incentive scheme is designed to pay for effort and achievement in a move towards more cost-effective and sustainable prescribing.

Monitoring and reporting of targets:

Targets based on base line Q4 data will be produced using ePact and Eclipse. Data will be produced monthly and payment will occur shortly after March 18 data is in. 100 points achievement will pay out £1.60 per patient on list size.

Points will start being awarded monthly in July 17, this gives practices 3 months to start making the necessary changes. Practices will achieve points either by going over target threshold or making a (significant) move towards the target, usually 10% (in absolute terms).

Use of Payment from Scheme:

Payments received from this Scheme may only be used to benefit patient care under the department of health rules attached in appendix B.

BACKGROUND

Entry Criteria

Practices need to engage with some actions by May 17 to join the incentive scheme.

All of these actions have already been communicated to practices. Some practices appear to have outstanding actions however.

The actions are:

- Stop all gluten free prescribing
- Stop all co-proxamol

- Write to all patients on the (selected) Brand to Generic switch list using the CCG letter template.

The letter templates are available at

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/branded_to_generic_patient_letter_gyw.docx

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/co-proxamol_switch_patient_letter_gyw.docx

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/gluten_free_withdrawal_patient_letter_gyw.pdf

There will be a monthly payment for work completed by your medicines management lead. They will also receive a payment for attending 80% of meetings that we arrange. Prescribing leads will need to submit a simple form signed by the practice manager to confirm that agreed actions are in progress and that the information has been passed on to prescribing colleagues and prescription clerks.

Below we describe the rationale for each indicator. Some references and approaches to making changes are noted. More detail of suggested audits will be given to Practice staff carrying out changes.

1. Percentage of Pregabalin as low cost
Target: 90% (or above) OR a 10% absolute improvement

A number of lower cost brands are now available, Axalid and Alzain are the most cost-effective, respectively. Alzain has a licence for neuropathic pain with some exclusions due to legal action from Pfizer.

Alzain is indicated for the treatment of peripheral and central neuropathic pain in adults, excluding the treatment of trigeminal neuralgia pain, acute herpetic pain, post-herpetic pain, or causalgia pain.
Axalid is now the MOST cost-effective but at present is only licensed for GAD and epilepsy.
Please use Axalid first line unless for pain, then use Alzain unless one of the above exclusions apply.

The letter templates are available at:

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/pregabalin_switch_to_alzain_patient_letter.docx

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/pregabalin_switch_to_axalid_patient_letter.docx

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/pregabalin_dose_optimise_cost_savings.pdf

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/pregabalin_to_alzain_dose_op_patient_letter.docx

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/pregabalin_to_axalid_dose_op_patient_letter.docx

2. Percentage of Tiotropium as low cost
Target: 70% (or above) OR a 10% absolute improvement

All patients remaining on tiotropium 18mcg (Spiriva Handihaler) should be offered the choice of Braltus or Spiriva Respimat.
Patients currently on Seebri, can be offered the above choices if they would prefer to go back onto tiotropium.

Letter templates:
http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/spiriva_switch_to_braltus_patient_letter.docx

http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/spiriva_caps_switch_to_spiriva_respimat_soltn_patient_letter.docx

3. Percentage of low cost quetiapine
Target: 95% (or above)

Practices should aim to change patients on lower doses to BD standard release as the first choice. Failing that a switch should be made to the most cost-effective brand available.

Owing to the recent demise of the brand Ebesque we need to make sure that cost-effective alternatives are employed. Ideally, patients should be switched to standard release quetiapine, failing that a cost-effective brand should be used. Both Biquelle and Zaluron work out as the cheapest options for the CCG.

Letter template:
http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/quetiapine_switch_to_biquelle_patient_letter.docx

Quetiapine dose optimisation cost savings:
http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/quetiapine_dose_optimise_cost_savings.pdf

4. Percentage of AD drugs prescribed cost-effectively
Target: 90% (or above)

Patients on original brands e.g. Aricept, Exelon, Ebixa, Reminyl changed to generic or low-cost brand. Rivastigmine patches to low-cost brand Alzest.

5. Percentage of self-care reduction by 10% or below target
Target: Below £100 per 1000 patients or a 10% reduction

Our self-care indicator shows items that either could or should be purchased OTC. Paracetamol is our biggest spend, patients can purchase this at around 1p per tablet, it costs the NHS around 4 times this plus the cost of staff time incurred.

Please use the resources provided to refer patients to purchase or advice from their pharmacist. We will be running media campaigns to promote this.

The GMC define prescribing as including the provision of a leaflet for advice but also the recommendation to purchase a medicines OTC or to see a pharmacist for that advice.

6. Percentage of lower cost emollients
Target: 60% (or above) OR a 10% improvement

The Thornton and Ross range of 'Zero' products is cost-effective. Patients can be offered a choice of three of the products, asked to try them and come back with which one they would like to have added to their repeat.

All lower cost products will be included in this indicator so there will be no need to change patients unnecessarily.

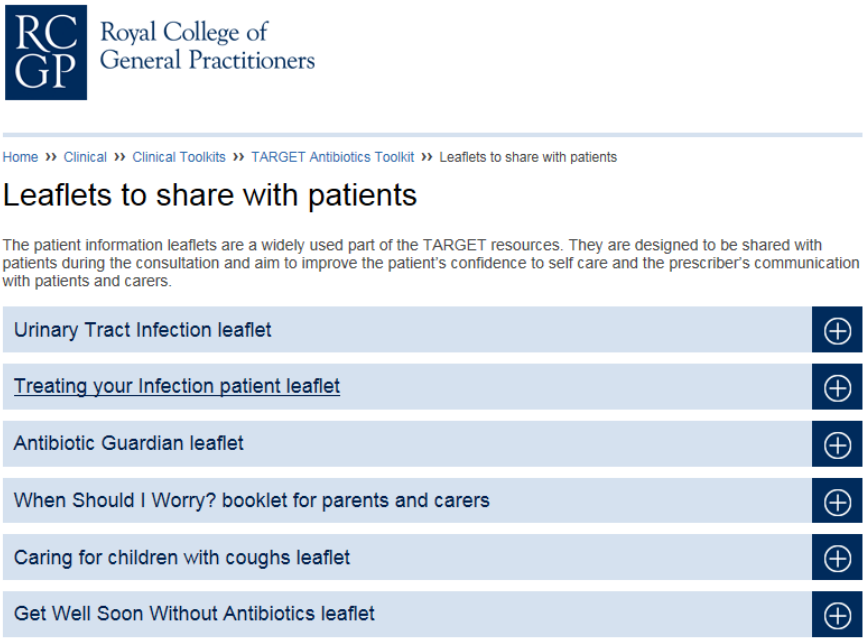
In the case of care homes requiring creams for dry skin, they should be advised to purchase these for the self-care of their patients.

Letter template:
http://nww.knowledgeanglia.nhs.uk/prescribing_gyw/prescribing_restriction/emollient_switch_patient_letter.docx

7. Below antibiotic volume threshold or a percentage reduction
Target: 1.161 items/STAR-PU or a 10% reduction

Use the below leaflets for patients who are not indicated antibiotics for their URTI or UTI following an assessment. The links to the leaflets are at

Target Antibiotic Toolkit Leaflets for Patients



Target for the CCG for antibiotic volumes are available at the PHE 'fingertips' website.

The Items/STAR-PU is a fixed 1.161 items/STAR-PU target value to stay below. The % broad spectrum is not in the QP but is still a CCG ISAF metric and will be a fixed 10% or below. Both will

continue to be reported in an antibiotic dashboard to support CCG performance monitoring and reporting.

PrescQIPP provide practice level antibiotic performance data here

Performance data is also available from the PHE website 'fingertips' here

A number of PrescQIPP resources around antibiotics are available here

Quality Premium Measure: Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups

Consists of three parts:

a) reducing gram negative blood stream infections (BSI) across the whole health economy
b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care
c) sustained reduction of inappropriate prescribing in primary care

Required performance in 2017/18

- 10% reduction (or greater) in all *E coli* BSI reported at CCG level based on 2016 performance data
- 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June15-May16) for 2017/18.
- 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.

The Trimethoprim: Nitrofurantoin ratio target is in the yellow highlighted column.

		Baseline data June 2015 to May 2016			
CCG	**CCG Code**	**TRIMETHOPRIM items**	**NITROFURANTOIN items**	**Trimethoprim :Nitrofurantoin items ratio**	**10% reduction Target to achieve FY 2017-18**
GYWCCG	06M00	22,207	11,490	1.933	1.740
England		**3,607,847**	**2,440,935**	**1.478**	
MEDIAN CCG				**1.556**	
MIN CCG				**0.327**	
MAX CCG				**2.838**	
MEAN CCG				**1.546**	

8. Percentage of sip feed spend – reduce prescribing and use more cost-effective
Target: 70% (or above) OR a 10% absolute increase

We have developed a new decision aid to help decide the best course of action using MUST scores. Often a food fortification approach is all that is needed. That can be done by giving patients/carers/homes the 'fabulous fortified feasts booklet'.

It is here. https://www.prescqipp.info/resources/send/67-nutrition-toolkit/529-fabulous-fortified-feasts-hd

We have also developed a pathway to decide which product to use, and when.

For GPs considering prescribing ONS:
http://nww.knowledgeanglia.nhs.uk/dietetics_gyw/food_first/for_gps_-_considering_prescribing_ons.pdf

GP guide to managing unwanted weight loss in adults:
http://nww.knowledgeanglia.nhs.uk/dietetics_gyw/food_first/gp_guide_to_managing_unwanted_weight_loss_in_adults.pdf

Guidelines for food fortification and ONS:
http://nww.knowledgeanglia.nhs.uk/dietetics_gyw/food_first/guidelines_for_food_fortification_&_ons_summary_pathway.pdf

9. Percentage of low cost BGTS
Target: 80% (or above) OR a 10% increase

Patients only on metformin do not need to test their blood glucose. There is a search on Eclipse live to identify those patients. Other patients may only need to test occasionally. Most patients will be able to use any of a number of machines that use the lower cost blood glucose testing strips e.g. GlucoRx Nexus or similar.

We will ensure the manufacturers send each practice a supply of machines, please re-order as necessary. At next review please give patients who need to continue testing the new machine, add the strip to repeat and remove the old strip from repeat. Please invite those who do not need to test to stop testing.

Paediatric type 1 patients and insulin pump patients should not be switched. All other patients can be switched to cost-effective choices if there is not a specified medical reason for their current meter.

10. Weekly log-in to Eclipse to review higher risk alerts
Target: 100% or RED alerts and review of 'other' alerts if no RED

System one practices need to continue performing weekly extractions and uploads. There is a document on the Eclipse site and the Eclipse help desk can help practices with this.

Once a week, after a Monday please open up Eclipse live and review ALL red alerts, if no RED alerts then review Amber alerts of specific project alerts that you have been asked to work on.

The CCG receives a monthly report of percentage of alerts that have been reviewed.

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Prescribing Leads Meeting
Feedback Form

Meeting date:	
Practice name:	
Prescribing Lead attendee name:	

	Action point	**Date completed**
What action points were received from Prescribing lead: ***(please detail)***		

I can confirm that the information received has been shared with: *(tick boxes)*

☐ GPs ☐ Nurses ☐ Prescription Clerks ☐ Other

Signature of Practice Manager: _____ **Date:**

Medicines Optimisation Support Group Response Form

Meeting date:	
Practice name:	
MOSG Lead attendee name:	

Action points to take back to practice:	**Date completed**

Actions to return to next meeting;
Training to complete:

Signature of Practice Manager: _____ **Date:**

http://nww.knowledgeanglia.nhs.uk/respiratory/adult_asthma_quick_ref_gyw.pdf

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Adult (≥18 years) Asthma Quick Reference Guide 2017/18

1st choice inhaler for each step is listed below in GREEN. 2nd choice in AMBER See over for further details

Key Points:

- Advise patients with asthma to stop smoking – refer to Great Yarmouth & Waveney Stop Smoking Service
- Start treatment at the step most appropriate to initial severity of their asthma.
- Patients should receive training for each device prescribed, and be able to demonstrate satisfactory technique.[1]
- Warn patients to monitor symptoms and return to clinic if no improvement or if symptoms worsen.
- Offer annual influenza vaccination to all patients with asthma that require continuous or repeated use of **inhaled or systemic** steroids or with previous exacerbations requiring hospital admission.
- Offer a one-off pneumococcal vaccination (PPV) to patients who require continuous or frequent repeated use of oral corticosteroids (i.e. at a dose equivalent to ≥20 mg prednisolone daily)[2]
- Check concordance and reconsider diagnosis if response to treatment is unexpectedly poor.[1]
- Ensure patient has a self-management plan.
- Perform yearly asthma review.
- Consider a spacer device for patients prescribed a metered dose inhaler (MDI) who are:
  - Having difficulty co-ordinating actuation and inhalation.
  - Receiving high doses of inhaled corticosteroid (ICS) (>800 mcg of beclometasone or equivalent daily).[3]

Stepping Up?

Think C.T.T.

- Compliance
- Technique
- Trigger factors

(Old Step 1) – Should no longer be used – Start at box below or higher step if needed. All below steps include SABA as needed

(Old Step 2) Regular ICS [BDP 400mcg/day]
Clenil 100mcg MDI 2 puffs BD or
Budesonide Easyhaler
Can decrease dose if controlled

(Old Step 3) - Initial:
Add LABA using combination inhaler [BDP 400mcg/day]
Fostair 100/6 1 puff BD MDI or Nexthaler DPI

(Old Step 3) – follow on: Benefit from LABA but inadequate response, increase ICS dose in combination inhaler [BDP 800mcg/day] Fostair 100/6 2 puffs BD MDI or Nexthaler or Relvar 92/22 1 puff OD. Once daily normally only after stability on twice daily. Consider Referral

If absolutely no response to LABA, review diagnosis
Stop combination device and start regular ICS [BDP 800mcg/day]
Clenil 200mcg MDI 2 puffs BD
If asthma still not controlled add a leukotriene receptor antagonist (LTRA). Review & Consider Referral

(S)MART

- Consider for patients on step 3 receiving frequent courses of oral steroids
- **Caution** – can become expensive and needs closer monitoring of patient scripts
- Use Fostair 100/6 inhaler 1 BD + 1prn (max 8/day) MDI or Duoresp Spiromax 160/4.5 1-2bd + 1prn (normal max 8/day)

(Old Step 4):
Consider trial of:

- Increasing ICS dose up to BDP 2000mcg/day – *see table overleaf for ICS/LABA combination inhaler options*
- Or addition of either a LTRA or theophylline

If trial of an add-on treatment is ineffective seek specialist advice before proceeding

(Old Step 5):
Refer to respiratory specialist

Stepping Down?

- Reduce ICS dose slowly
- Aim to use the lowest effective ICS dose
- Consider a treatment review every 12 weeks

Flow chart based on recommendations from the British Thoracic Society and Scottish Intercollegiate Guidelines Network:
This version: Jan 2017 Review: Jan 2019

	Old Step 1	Old Step 2	Old Step 3 -initial	Old Step 3 – follow on		Old Step 4	Old Step 5
				LABA benefit but inadequate response	LABA no benefit	Taylor therapy to patient/preferred device	
1st Choice	Step up treatment to include regular ICS. All new steps include when required SABA	**Clenil 100mcg (MDI)** **2 puffs BD [BDP 400mcg]**	**Fostair 100/6mcg (MDI)** **1 puff BD [BDP 500mcg]**	**Fostair 100/6mcg (MDI)** **2 puffs BD [BDP1000mcg]** **or Relvar 92/22 1 puff OD [BDP 1000mcg]**	**Clenil 200mcg (MDI)** **2 puffs BD [BDP 800mcg]**	**Fostair 200/6 (MDI)** **2 puffs BD [BDP 2000mcg]**	**Refer to specialist**
Spacer	Space Chamber Plus (MDI only) also available in a compact	Space Chamber Plus (MDI only) also available in a compact	Space Chamber Plus (MDI only) also available in a compact	Space Chamber Plus (MDI only) also available in a compact	Space Chamber Plus also available in a compact		
2nd choice	Use Salbutamol MDI as SABA of choice and (terbutaline turbohaler) as second choice. Salbutamol MDI can be used with spacer	Only if beclometasone not suitable: **Easyhaler Budesonide 100mcg (DPI)** **2 puffs BD [BDP 400mcg]**	**Fostair NEXThaler 100/6mcg (DPI)** **1 puff BD [BDP 500mcg]**	**Fostair NEXThaler 100/6mcg (DPI)** **2 puffs BD [BDP 800mcg]**	Only if beclometasone not suitable: **Easyhaler Budesonide 200mcg (DPI)** **2 puffs BD [BDP 800mcg]**	**Fostair NEXThaler (DPI) 2 puffs BD [BDP 2000mcg]**	
Spacer		Not appropriate	Not appropriate	Not appropriate	Not appropriate		
3rd choice	Only if salbutamol not suitable: **Terbutaline Turbohaler** **1 puff prn**		Only if breath actuated device required: **DuorespSpiromax 160/4.5 (DPI)** **1 puff BD [BDP 400mcg]**	Only if breath actuated device required: **DuorespSpiromax 320/9 (DPI)** **1 puff BD [BDP 800mcg]**		**DuorespSpiromax 320/9 (DPI) 2 puffs BD [BDP 1600mcg]**	
Spacer	Not appropriate	Not appropriate	Not appropriate	Not appropriate	Not appropriate		

Key

MDI - Metered dose inhaler
DPI - Dry powder inhaler
BAA - Breathe actuated aerosol
ICS - Inhaled corticosteroid
SABA - Short acting ß2 agonist
LABA - Long acting ß2 agonist
LTRA - Leukotriene receptor antagonist
SMART - Single maintenance and reliever therapy – MART with Fostair
[BDP xxxmcg] - Equivalent dose of beclometasone dipropionate

Complete control of asthma: The 6 measures[1]

1. No daytime symptoms
2. No night-time awaking due to asthma
3. No need for rescue medication
4. No exacerbations
5. No limitation on activity including exercise
6. Normal lung function (FEV1 and/or PEF>80% predicted or best

With minimal side-effects

Criteria for specialist referral in adults[1]

- Prominent systemic features (myalgia, fever, weight loss)
- Unexplained restrictive spirometry
- Suspected occupational asthma
- Monophonic wheeze or stridor
- Chronic sputum production
- CXR shadowing
- Unexpected clinical findings (i.e. crackles, clubbing, cyanosis)
- Persistent non-variable breathlessness
- Poor response to asthma treatment/uncontrolled at step 4
- Marked blood eosinophilia (>1 x 109/l)
- Severe asthma exacerbation
- Diagnosis unclear

References:
1. British Thoracic Society and Scottish Intercollegiate Guidelines Network (SIGN).
2. Department of Health. The Green Book - Immunisation against infectious disease.
3. National Institute for Health and Clinical Excellence (NICE). Clinical Knowledge Summaries (CKS) Accessed via http://www.cks.nhs.uk

http://nww.knowledgeanglia.nhs.uk/respiratory/adult_copd_quick_ref_gyw.pdf

Updated January 2017

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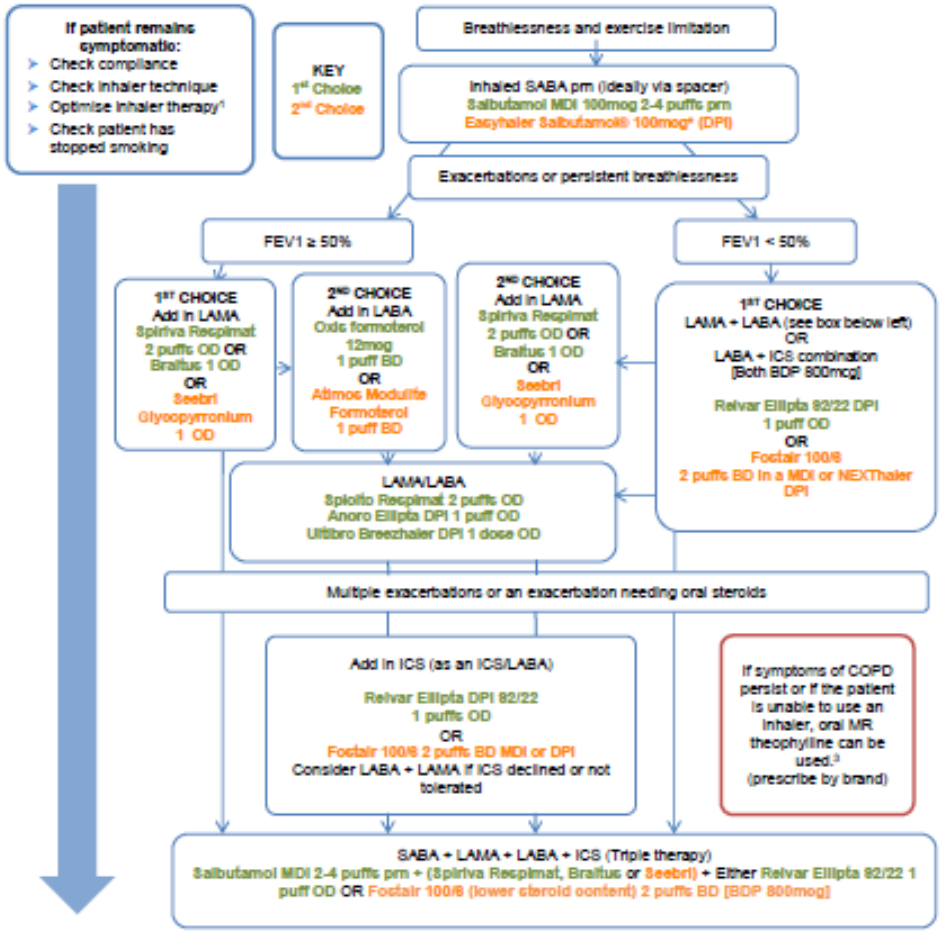
HealthEast

Adult COPD Quick Reference Guide 2017/18

Key Points:

- Advise all patients with COPD to stop smoking – refer to The Great Yarmouth and Waveney Stop Smoking Service if necessary.
- Provide pulmonary rehabilitation for all who need it (see overleaf) – refer to JPUH Pulmonary Rehab service.
- Be aware of the potential risk of developing side effects (including non-fatal pneumonia) in people with COPD treated with ICS. Long-term use of ICS will contribute significantly to the already higher risk of osteoporosis in COPD patients
- Offer a one-off pneumococcal vaccination and an annual influenza vaccination to all patients with COPD.
- Review people with mild or moderate COPD at least once a year and those with very severe COPD at least twice a year[1].
- Ensure patients have a self-management plan detailing how to recognize and respond to the early signs of an exacerbation[2].



Flow Chart based on recommendations from the British Thoracic Society and Scottish Intercollegiate Guidelines Network[1]

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Updated January 2017

	SABA	LABA	LAMA	LABA + ICS
1st Choice	Salbutamol MDI 100mcg 2 - 4 puffs PRN	Oxis formoterol 12mcg 1 puff BD	Spiriva Respimat 2 puffs OD Braltus 1 dose OD	Relvar Ellipta 92/22 DPI 1 puffs OD
spacer	Space Chamber Plus or Space chamber Compact	Space Chamber Plus or Space chamber Compact	Not appropriate	Not appropriate
2nd choice	Easyhaler Salbutamol® 100mcg* (DPI) [unlicensed indication] 1-2 puffs PRN	Atimos Modulite® 12mcg (formoterol)* (MDI) 1 puff BD	Seebri Glycopyrronium Braltus 1 dose OD	Fostair 100/6 MDI or NEXThaler DPI 2 puffs BD
spacer	Not appropriate	Not appropriate	Not appropriate	Space Chamber Plus or Space chamber Compact

Key

MDI	- Metered dose inhaler
MRC	- Medical Research Council
DPI	- Dry powder inhaler
PRN	- When required
SABA	- Short acting β2 agonist
LABA	- Long acting β2 agonist
LAMA	- Long acting muscarinic antagonist
ICS	- Inhaled corticosteroid
BDP xxmcg	- Equivalent dose of beclometasone dipropionate
BD	- twice a day
PRN	- when required
OD	- once a day

Inhaler licenses

Fostair pMDI is the only licensed MDI. DuoResp Spiromax inhalers are ICS/LABA combination inhalers licensed for use in COPD. Only high dose Symbicort and Seretide Accuhaler and low dose Relvar are licensed. Seretide Evohaler is unlicensed.
All remaining ICS/LABA combination inhalers are currently unlicensed in COPD.
If patient cannot use licenced device or suffers from excessive side effects from licensed product - consider using LABA/ICS combination MDI 'off license' with a spacer e.g. Sirdupla.
Inform patient that treatment is off licence if appropriate.

Mucolytic therapy[1]

- Consider in people with a chronic productive cough and continue use if symptoms improve.
- Do not routinely use to prevent exacerbations.
- Step down to maintenance dose or stop once condition improves.

Exacerbations[1]

- Patient need to have the local management plan booklet
- Give people at risk of exacerbations a course of antibiotic and corticosteroid tablets to keep at home (SOS pack)
- Monitor the use of these drugs and advise people to contact a healthcare professional if their symptoms do not improve.

Oxygen

- Patients who are not hypoxic do not benefit from oxygen.
- Patients who are hypoxic with oxygen saturations of <92% when stable should be considered for long term oxygen.
- Patients should be assessed by the Respiratory Nurses at JPH - consider referral to secondary care first to ensure the patient has been medically optimised.
- See Quick Pages for more information.

Criteria for specialist advice

Referral for advice, specialist investigations or treatment may be appropriate at any stage of disease, not just for people who are severely disabled.[1]

- Diagnostic uncertainty
- Onset of cor pulmonale
- Dysfunctional breathing
- Bullous lung disease
- Rapid decline in FEV1
- Haemoptysis
- The individual requests a second opinion
- Assessment for lung volume reduction surgery or lung transplantation
- Assessment for oxygen therapy, long-term nebuliser therapy or oral corticosteroid therapy
- Symptoms disproportionate to lung function deficit
- Onset of symptoms under 40 years or a family history of alpha-1 antitrypsin deficiency

Advance planning and end of life care

- Offer discussions about advance care planning.
- Agree an anticipatory care plan for future exacerbations/ complications.
- Ensure end-of-life care is an integral component of the care plan of people with advanced COPD.

Pulmonary rehabilitation (PR)

- PR should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above). The education element of PR can be offered to patients with an MRC grade 2 and above.
- PR is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.
- Refer patients who need pulmonary rehabilitation to JPUH PR service.

Nebuliser[1]

- Consider a trial of a nebuliser for people with distressing or disabling breathlessness despite maximum therapy with inhalers. Patients need to buy the nebuliser.
- Continue only if there is an improvement in symptoms, daily living activities, exercise capacity or lung function.

Oral corticosteroids[1]

- Maintenance use of oral corticosteroids in COPD is not recommended.
- Some people with advanced COPD may need maintenance treatment if therapy cannot be stopped after an exacerbation – refer to secondary care.
- Keep dose as low as possible, monitor for osteoporosis and offer prophylaxis.
- Issue and discuss Steroid Warning Card

References:
1. National Institute for Health and Clinical Excellence (NICE). Chronic Obstructive Pulmonary Disease (COPD) CG101. June 2010
2. National Institute for Health and Clinical Excellence (NICE). Clinical Knowledge Summaries (CKS) – COPD. Last updated March 2012. Accessed via http://www.cks.nhs.uk
3. British Medical Association and Royal Pharmaceutical Society. British National Formulary (BNF). Issue 72 September 2016.

DH Guidance on approved uses of Incentive Scheme Funds

Annex B

PRIMARY CARE TRUSTS INCENTIVE SCHEME PAYMENTS
FSHL (95)20 Prescribing Incentive Schemes 1995

Approved Uses

- 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).

- Payments to dieticians or counsellors providing advice on diet, lifestyle, alcohol consumption or smoking.

- The purchase of material or equipment which will enhance the comfort or convenience of patients of members of the practice including furniture, furnishings, security features, vending machines or heating/air conditioning for the practice.

- The purchase of computers including hardware and software.

- Non-recurring staff costs.

- Initiatives to improve prescribing.

- 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.

- Investment in existing practice premises where the improvement or development proposals are consistent with the Primary Care Investment Plan.

Purposes for which Practice Incentive Surplus Payments may *not* be spent

- The purchase of services or equipment which are unconnected with healthcare.

- To reduce a practice's contribution to the employment costs of existing practice staff.